Sliding Fee Scale
Neighborhood Health Association

Income Eligibility Form

The Sliding Fee Scale is a method for providing reduced charges to patients who are not eligible for benefits under other types of social programs. In order to be eligible for participation in this program, the following application must be completed along with documentation of income and submitted for review.

I prefer not to be considered for the sliding fee discount.

Head of Household:__________________________ Total number in Household #_____

Social Security Number_______________________

Write the names of everyone in your household, whether they receive in come or not, including yourself.

Gross Monthly income must include all earned income, child support, alimony, pension, social security, and unemployment.

Name of Household member	DOB	SS#	Gross Income
_________________________	________	____________________	___________________
_________________________	________	____________________	___________________
_________________________	________	____________________	___________________
_________________________	________	____________________	___________________

Address/City /State/Zip____

Phone_____________________________ Employed YES or NO (circle one)

Employer's Name and Address____

____

I certify that as of this date the above information is correct to the best of my knowledge. I understand that no adjustments will be made unless I submit documentation of income. Any falsification will jeopardize discount and result in full payment of bill. Payment is expected at the time of service.

Signature____ Date_______________

Percent to Pay___________ Reviewer__________________________ Date_______________