AllCare
HEALTH CENTER

SLIDING FEE APPLICATION

Proof of Household Income to include one of the following: most recent 30 days of consecutive pay stubs, prior year tax return, current Social Security/disability benefits, Proof of income from the social security office or Workforce office.

PATIENT INFORMATION:

Patient's Name: _____ Date of Birth: _____

Address: _____

Telephone Number: (_____) _____

Others in household - please complete for everyone living in your household:

Name	**Relationship**	**Date of Birth**

Total number in household: _____

HOUSEHOLD INCOME VERIFICATION: ____ I do not wish to disclose my income. I am not interested in receiving any discounts.

Employed _____ Unemployed _____ Disability _____ Other _____

Place of employment: _____

Yearly Gross Income (before taxes): $_____ Monthly Gross Income: $_____

PATIENT AGREEMENT: *By signing this form, I agree that all information given is a complete and accurate statement to the best of my knowledge. I authorize All Care Health Center (ACHC) to check all information presented. I agree to report any changes in income, change of insurance coverage, or household size to ACHC immediately. I understand that any person who obtains or attempts to obtain by illegal means, services to which he/she is not entitled, may be charged under the applicable state and federal statutes. I authorize permission for Program designees to review my records for auditing purposes:*

****By signing below, I agree to bring in proof of income within 30 days to receive any discount for which I am eligible.**

Signature of Applicant: _____ Date: _____

Signature of Intake Representative: _____ Date: _____

OFFICE USE ONLY

Annual Household Income: _____ Date Verified _____ Poverty %: _____ Slide scale: _____

Updated 7/12/19

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Documents to bring as proof of income for the Sliding fee Scale

Choose 1 from the options listed below

You have 30 days from the application date to provide the proof of income

Documents accepted as proof of income (POI):

- ☐ **Employment wages**
  - *2 most recent if paid **biweekly** (30 days of consecutive paystubs)
  - *4 most recent if paid ***weekly*** (30 days of consecutive paystubs)
  - *2 most recent if paid ***monthly*** (60 days of consecutive paystubs)

- ☐ **Social Security wages** (Social Security Administration Monthly benefit letter dated with most recent calendar year, NO 1099 FORMS)

- ☐ **Social Security Disability** (Social Security Administration Monthly benefit letter dated with most recent calendar year, NO 1099 FORMS)

- ☐ **Prior year tax return** (This is good until April 15 of current year, NO W2s)

- ☐ **Current year tax return** (NO W2s)

- ☐ **Proof of income from the Social Security office** (Social Security Earnings Record)

- ☐ **Unemployment** (Unemployment Benefit Statement must be dated within the last 3 months)

If you do not have any of these documents, please contact our *Patient Financial Advocate* at 712-256-6589 to discuss other documents determined on an individual basis and at the discretion of management.

Updated 07/12/19