

## Application for Sliding Fee Program (Payment Assistance)

**Complete this form if you are applying for payment assistance or re applying for the Sliding Fee Program**

Your sliding fee discount will be based on proof of your family income and size. If you do not have proof of income with you today, you might qualify for a temporary sliding fee discount for 1 month. Next time you come in for an appointment, please bring in proof of income.



**Need help filling this form out? Ask a CMU Health Employee.**

- I want to apply for the Sliding Fee Program at CMU Health. Please complete all fields on the form.
- I do not want to apply for the Sliding Fee Program. *\*If not applying, please complete only the fields marked with an \*: Name, Birthdate, signature, and today's date.*

**\*Name:** \_\_\_\_\_ **\*Birthdate:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ ( ) Home ( ) Work ( ) Cell

**City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ **Resident of a Secured Facility:**  Yes  No

**Do you have income?**

Yes  No **Who provides you with food and shelter?** \_\_\_\_\_

**List FAMILY:** Do not include anyone that is not claimed as a dependent by a family member. Do include all people claimed as dependents who live together and are related to the patient by blood, marriage, or adoption. You may also include anyone that a family member claims as a dependent, regardless of where they live.

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Has income?**  Yes  No

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Has income?**  Yes  No

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Has income?**  Yes  No

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Has income?**  Yes  No

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Has income?**  Yes  No

**Do you have proof of family income today?** Please include proof of income for anyone in your 'Family' listed above.

Yes, the income is received...  Weekly  Every other Week  Monthly  Yearly  Seasonal/Varies

No, please list your **Estimated** yearly family income \$ \_\_\_\_\_

*If you don't have any proof of income with you today, you may qualify for a temporary 1 month sliding fee discount. If you provide a signed letter from any person or agency that you receive food and shelter from, you may qualify for a 365-day sliding fee discount.*

**Patient Acknowledgement:**

I declare that the information, as stated above, is true and factual.

**\*Patient or Guardian Signature:** \_\_\_\_\_ **\*Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_



### This Section is for Staff Use Only

**Total Number of Persons in Family (from names listed above, include Patient):** \_\_\_\_\_

**Total Gross Annual Family Income from all Sources (BASED UPON PROVIDED PROOF OF INCOME ONLY):** \$ \_\_\_\_\_

Those not residing at family address can self-attest instead of providing proof of income.

Proof of income should include: Wages, Social Security, Public Assistance, Unemployment, Pension Payments, Alimony, Child Support or Other Cash

**APPROVED STANDARD SLIDE – 365 Days with Proof of Income:**

- Patient Qualifies for Standard Sliding Fee Category:  B  C  D  E (  F No Discount )
- Proof of Income Received (If 'No Income' the SIGNED verification letter of no income is considered Proof of Income)

**APPROVED PRESUMPTIVE SLIDE – 1 month with NO Proof of Income:**

- Patient Qualifies for Presumptive Sliding Fee Category:  B  C  D  E (  F No Discount )
- Patient listed their 'Estimated Income' OR if 'No Income' listed who provides them food and shelter on this form

**Staff Acknowledgement:** By initialing, I am confirming that the Sliding Fee Application is complete, and the information has been accurately entered into the Patient's Registration in its entirety.

**Staff Initials:** \_\_\_\_\_ **Date Application Completed:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_