

1501 Division Street

Baltimore, MD 21217

**SLIDING FEE 30 DAY ELIGIBILITY FORM**

|  |  |  |
| --- | --- | --- |
| **Name:** |  |  |
| **Address:** | Completion of this form is to establish coverage through a discounted payment program to cover part or all of your medical expenses. Completion of this form is only for temporary coverage and will expire in 30 days without required supporting documentation being provided. The following documents (examples of documents provided) must be provided within 30 days to avoid being charged full costs of services incurred during this 30 day coverage:**Proof of Income** (all household members): Pay stubs to account for most recent monthly income, income tax returns with W-2, Social Security/government benefit letter, child support, alimony, investments.\*reference SFS Policy for more details as needed |
| **City, State:** |
| **Zip Code:** |
| **Telephone:** |
| **Social Security #:** |
| **Date of Birth:** |
| **Chart Number:** |

Number of people living in your home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you receive any income from any of the following sources, and if so, how much (annually)?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sources** | **You** | **Your Spouse** | **Your Children** | **Other Person** | **Total Sources** |
| Household Income |  |  |  |  |  |
| Social Security |  |  |  |  |  |
| Public Assistance |  |  |  |  |  |
| Retirement Pension |  |  |  |  |  |
| Rental Income |  |  |  |  |  |
| Interest Income |  |  |  |  |  |
| Child Support, Alimony |  |  |  |  |  |
| Other (Specify) |  |  |  |  |  |
| **Total** |  |  |  |  |  |

Date placed on 30 Day SFS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date 30 Day SFS Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge by signing below that information provided on this form is true and complete to the best of my knowledge. I understand the supporting documents must be provided by the 30 day expiration date to avoid paying the full medical costs incurred during the 30 day period. Upon receipt of supporting documents, I acknowledge to be placed on a 6 month sliding fee eligibility period that will require recertification every 6 months.

|  |  |
| --- | --- |
| **Patient/Guardian Signature:** | **Date:** |

|  |  |
| --- | --- |
| **Staff Signature:** | ***Clinic Purpose Only, Circle One: <100% 101-150% 151-175% 176-200% >200%******Income Level/Discount: See sliding fee scale for corresponding visit costs*** |