

1501 Division Street

Baltimore, MD 21217

**SLIDING FEE 6 MONTH ELIGIBILITY FORM**

|  |  |  |
| --- | --- | --- |
| **Name:** |  |  |
| **Address:** | It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file at our center, in strict confidence. You are being placed on a discounted fee program to cover part or all of your medical expenses. Supporting documents (examples listed below) will need to be updated every 6 months.  **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:** |

|  |
| --- |
| Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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** |  |  |  |  |  |

Give Names, DOB, and SSN of all individuals living in the household.

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| --- | --- | --- |
| Name: | Date of Birth: | Social Security Number: |
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Date placed on 6 Month SFS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date 6 Month SFS Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I declare the above information is true and have given Total Health Care permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if any information provided should change, that I am required to notify staff at my next visit to the clinic. I acknowledge to being placed on a 6 month sliding fee eligibility period that will require recertification every 6 months.

|  |  |
| --- | --- |
| **Patient 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*** |