North Side Christian Health Center

SLIDING FEE APPLICATION FORM

Parent/Guardian Name: _____ **Date of Birth:** _____

Patient Name:_____ **Date of Birth** _____

A. Please list all persons related by birth, marriage or adoption who reside at your same address. Include related sub-family members such as mother, cousin, etc. who share income, food and rent—

#	Name	Relationship	#	Name	Relationship
1			6		
2			7		
3			8		
4			9		
5			10		

B. Indicate ALL sources of income and amounts for your household—

Wages/Salary	$	Allowances/Gifts	$	VA Benefits	$
Unemployment Comp	$	Interest/Dividends	$	Alimony	$
Self-Employed	$	Scholarship/Grant	$	Training Stipend	$
Social Security/SSI	$	Support from Family	$	Rental Income	$
Child Support	$	Disability	$	Other (specify)	$
Workers' Comp	$	Pension/Retirement	$		

TOTAL INCOME $: _____

I attest that the information provided above is true and correct. I give North side Christian Health Center permission to verify the information regarding my financial status. **I understand that documents verifying income must be provided within 30 days of the date of visit to qualify for a sliding fee discount**. If proof of income documents are not received, then I understand that I will be responsible for the full fee of the visit in its entirety.

_____ _____

Applicant Signature *(patient/parent/guardian)* Date

******************************OFFICE USE ONLY********************************

Verified Income $_____ Number in Household _____

Scale financial class assigned based on above income and household size _____

Re-Certification Date _____ ☐ MEDICAL ☐ DENTAL

NSCHC Staff Signature/Date _____

(Rev 5-18)