# Corktown Health Center/HELP - Sliding Fee Application

It is the policy of Corktown Health Center (CHC)/ HELP to provide quality medical care and behavioral health services to all persons in need of care, regardless of income and/or the inability to pay. Please complete the following information so that CHC will be able to determine your eligibility for discounted services. You will be reassessed for the sliding scale every six months and you will be required to provide updated proof of income.

**Patient's Name**: _____ **Preferred Name**: _____

**Date of Birth**: _____ **Last four digits of Social Security Number**: _____

Do you have commercial health insurance, Medicare, Medicaid, Healthy Michigan, VA health benefits or participate in any program that pays for medical services?

☐ Yes ☐ No ☐ Not Sure

**HOUSEHOLD**

**A "household" includes legal children, a civil union partner or married spouse, and legal dependents.** Please list the name of individuals in your household and relation to you.
Please use the back of this form for additional space.

| Names of individual living in household (including yourself) | Relation to you |
|---|---|
| | |
| | |
| | |
| TOTAL number of people in household: | |

**ANNUAL HOUSEHOLD INCOME**

| Source of Income | Self | Partner | Other | Total |
|---|---|---|---|---|
| Gross wages, salaries, tips, etc | | | | |
| Social Security (SSI or SSDI) | | | | |
| Unemployment Benefits | | | | |
| Investment Income | | | | |
| Other | | | | |
| **TOTAL INCOME** | | | | |

**PLEASE READ AND SIGN**

I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charged the **full fee of my visit** if I do not bring in documentation of income by my **third visit or within 60 days of my first visit**, whichever comes first. I understand that I am required to notify CHC/ HELP if my income level changes or if I become insured. If there are changes, I will be re-assessed for the sliding fee scale.

Print Name: _____

Patient Signature: _____ Date: _____

Guardian Signature (if applicable) _____

FOR INTERNAL USE ONLY

☐ $0 - RW 0-100%
☐ $5 - Non-RW 0-100%
☐ $10 - RW 101-150%
☐ $10 - Non-RW 101-150%
☐ $20 - RW 151-200%
☐ $20 - Non-RW 151-200%
☐ Full Fee (not eligible) greater than 200%

| Reviewed By | |
|---|---|
| Pending | Effective |
| Effective Date | |
| Termination Date | |