##  Patient Account Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Applicant Information |
|

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** |  |  |  |
|  | **Last** | **First** | **M.I.** |
| **Address:** |  |  |  |
|  | **Street Address** |  | **Apartment/Unit #** |
|  |  |  |  |
|  | **City** | **State** | **ZIP Code** |
| **Date of Birth:** |  |  **Social Security Number:** |  |

|  |  |
| --- | --- |
| **Home Number:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  |

 |
|  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Household Members** | **Relationships** | **DOB** | **Income****Monthly** |  | **ADDITIONAL HOUSEHOLD MEMBERS** | **Relationship** | **DOB** | **Income Monthly** |
|   | **APPLICANT** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

**Do you have Insurance?** [ ] **Yes** [ ]  **No (If Yes, please provide copy of Insurance Card)**

**I would like an appointment to discuss my insurance options or better understand my coverage.** [ ] **Yes** [ ]  **No**

**Please provide proof of all household income and family size. Please see attached Documentation checklist (reverse side). Failure to provide sufficient proof will result in the return of your application and delay in approval.**

**I hereby request Neighborhood Health Center to make a determination of my eligibility for the sliding fee program. I understand that the information, which I submit concerning my family income and size, is subject to verification. I also understand that if information, which I submit, is determined to be false, I will be liable for all services at full charge. In signing this application I affirm that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Neighborhood Health Center of all changes in my insurance information and should I fail to do so payment in full will be my responsibility. I understand that Enrollment staff may use my application information and income verification to help me with additional medical and social needs, if requested.**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Office Use Only: Date Effective: \_\_\_\_\_\_\_\_ Household Income per year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SFS:** [ ]  **A $3** [ ]  **B $15** [ ]  **C $40** [ ]  **D $50** [ ]  **E $60**

[ ] **Review By Staff: \_\_\_\_\_\_\_**

**Patient case sent to Social Supports (as applicable)** [ ] **Yes** [ ] **No**

[ ] **Entered Into Athena Medical and Dental:**

[ ] **Uploaded into Athena:**

**Supervisor/Manager Review: \_\_\_\_\_\_\_\_**

**Additional Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NEIGHBORHOOD HEALTH CENTER**

**SLIDING FEE DOCUMENTATION CHECKLIST FOR ELIGIBILITY**

**Applicant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Application Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***\*Your application cannot be completed until all required documents are received.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROOF OF RESIDENCE\*-** You must show ONE of the documents listed below to document your home address. Photocopies are acceptable.

**\* FOR CHILDREN, BIRTH CERTIFICATES, SCHOOL REPORT CARDS OR FEDERAL TAX RETURN SHOWING THEM AS DEPENDENTS ARE THE ONLY ACCEPTABLE PROOF FOR CHILDREN**

**RESIDENCY/HOME ADDRESS** *(this must match the home address on your application, and the proof must be dated within 2 months of the application)*

* NYSID card with address
* Driver’s license
* Property tax records or mortgage statement
* Letter/lease/rent receipt with home address from landlord
* Postmarked envelope, postcard, or magazine label with name and date (cannot use if sent to a P.O. Box)
* Utility bill (gas, electric, cable), bank statement or correspondence from a government agency which contains name and address

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROOF OF CURRENT HOUSEHOLD INCOME:** You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. Submit all that apply. Provide the most recent proof of income before taxes. The proof must be dated within the last 2 months, and include the employees name and show gross income for the pay period.

|  |  |  |
| --- | --- | --- |
|  **Wages and Salary** □ Paycheck stubs (4 consecutive weeks) □ Letter from employer, signed and dated on company letterhead Income tax return – W-2\*\* □ Business records |  **Social Security** **□** Award letter/certificate □ Benefit check □ Correspondence from Social  Security Administration |  **Child Support/Alimony** □ Letter from person providing  support □ Letter from court □ Child support/alimony check stub |
|  **Self-Employment** □ Signed and dated income tax return and all Schedules\*\* □ Records of earnings and expenses |  **Unemployment Benefits** □ Award letter/certificate □ Benefit check □ Correspondence from NYS  Department of Labor |  **Interest/Dividends/Royalties** □ Statement from bank, credit union or financial institution □ Letter from broker □ Letter from agent |
|  **Veteran’s Benefits** □ Award Letter □ Benefit check stub □ Correspondence from Veterans  Administration |  **Worker’s Compensation** □ Award letter □ Check stub |  **Income from Rent or Room &**  **Board** □ Letter from roomer, boarder,  tenant □ Check stub |
|  **Private Pensions/Annuities** □ Statement from pension/annuity |  **Military Pay** □ Award letter □ Check stub |  **Support from Other Family** **Members** □ Signed statement or letter from  family member |

**\*\****W-2s or income tax returns for other than self-employed may be used for applications prior to April of the*

 *following year. If later, you must include another form of documentation.*

**Dependents:** We consider household income based on IRS dependency guidelines. You may not list a dependent here if you would not be able to include them on your tax return. Reference (http://www.irs.gov/taxtopics/tc354.html)