COASTAL HEALTH ALLIANCE

[ ] Point Reyes Community Health Center [ ]  Bolinas Community Health Center [ ] Stinson Community Health Center

**PROGRAM SCREENING APPLICATION**

1. **PATIENT NAME BIRTHDATE ADDRESS W/ZIP CODE PHONE**

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

Patient’s Employer or Source of Income: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient’s Social Security Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Household Members Birthdate Relationship to Patient Source of Income**

**2**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your household total gross income per month? \_\_\_\_\_\_\_\_\_\_\_ #of household members?\_\_\_\_\_\_\_\_**

­­­­­­­­­­­­­­For Office Use Only:

Programs Screened for:

□ MEDI-CAL □ CHDP □ FAM-PACT □ CDP □ COVERED CALIFORNIA

□ KAISER KIDS

Program Previously Applied for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Share of Cost\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Staff\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SLIDING FEE SCALE ELIGIBILITY FORM**

To apply for sliding fee scale, you must provide proof of income and sign the affidavit below. All information for this voluntary program is confidential. If you choose to not complete the sliding fee application (including the required documentation) and are a private pay patient, payment is due at the time of service.

You must provide Proof of Income within 30 days from date of application to be eligible for future sliding fee scale discounts. Your eligibility for this program is for 12 months, and must be renewed annually.

**ONE MONTH’S DOCUMENTATION OF ANY AND ALL OF THE FOLLOWING SOURCES OF INCOME:**

|  |  |
| --- | --- |
| **Pay check stubs/statements less than 60 days old** | **Alimony checks/statements** |
| **Signed Statement from employer (if paid in cash)** | **Interest and/or dividend income statements** |
| **Workers Compensation, SDI, Social Security, Unemployment or Pension check stubs/statements**  |
| **OR current federal income tax return** |

# AFFIDAVIT

**I understand the medical services I am receiving today may be billed to me at 100% of the cost. I further understand that it is my responsibility to provide the clinic with proof of my family income.**

**If my income is within the Sliding Fee Scale guidelines, fees may be reduced. I also understand that I may re-apply if my financial circumstances change at any time.**

**I certify under penalty of law that the information I’ve provided is correct.**

|  |  |  |
| --- | --- | --- |
|  |  |  |

Patient or Responsible Party Signature Clinic Staff Print Name Date

## For Office Use Only:

|  |
| --- |
| *Approved:\_\_\_\_\_ Denied \_\_\_\_\_ 30 Day Eligibility\_\_\_\_\_\_\_Additional Information Requested Due\_\_\_\_\_\_\_. By:\_\_\_\_\_\_\_\_\_ Additional Information Received date\_\_\_\_\_\_\_\_\_* *List Items Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Sliding Fee Scale See Federal Poverty Income Level Guidelines* *Medical Category:* ***A B C D E****Mental Health Category:*  ***A B C D E****Acupuncture Category:* ***A B C D E****Dental Category**:* ***A B C D E****Entered into Computer: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ By:\_\_\_\_\_\_\_\_ Patient Account Number :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| *Comments/Notes:* |
|  |

*2/27/2019 updated*