Sliding Fee Discount Program Membership Application

Household Members

Total number of people in your household who you share expenses with including yourself, spouse, boyfriend, girlfriend, partner, other family members and all children under your care_____

Please list **ALL** members of the household. Add additional paper if needed.

Legal Name	Relationship	Date of Birth	Employed
	SELF		Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N

Income

List everyone in your household who is employed.

Name	Employer	Gross Monthly Income-Before Taxes

List any other monthly income for your household including Children SSI, TANF, and SS Death benefits.

Social Security	$.	Workers Comp/Disability	$.	Self-Employment	$.
Veterans Benefits	$.	Alimony/Child Support	$.	TANF	$.
Unemployment	$.	Interest/Dividend Income	$.	Other Income	$.

Unemployed or No Income

Please **INITIAL** if you are currently unemployed or have no income. By initialing you are documenting that you have zero or no income. To assist in documenting zero or no income, I understand that One Health may run a soft credit check. The results of this soft credit check will not impact your credit rating. It will help assist in One Health determining if I am eligible for the SFDP. By indicating no income you will be initially granted a 30 day approval.

Unemployed		No Income	

Agreement and Signature

All information on this form is a true statement of income at the time of my signature. I understand that if I qualify as a member of the Sliding Fee Scale Discount, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal from care. I understand that One Health is a federally funded organization, and that this self-declaration is subject to audit. I agree to report any changes within 30 days.

Initial determinations are ONLY valid for 30 days from acceptance date without supporting documentation for income amounts. To extend to one year, provide proof of income.

Signature	**Date**
Address	**Phone Number**

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Internal Use ONLY:

	Date	Initials
Application Received		
Documents Received		
Incompete-Request for Documents sent		
Completed		

Income

Source	Frequency	Amount	Annual
Total			
Family Size			

Slide Category

	Category	Begin Date	End Date
One Health Slide			
Preliminary Slide			
Family Planning Slide			
Preliminary Slide			

DO NOT require proof of income for Family Planning services slide but can request. DO NOT consider Social Security disbursements, child support, food stamps, TANF, SSI for Family Planning services slide.

No Income – Soft credit check

Results	Date	Initials

Complete

	Date	Initials
Entered in EHR		
Entered in Dental EHR		
Letter to Patient		

Additional notes