Sliding Fee Discount Program (SFDP) Membership Application

Name of Patient: ____ Date: ____________________

My total family or household income (before taxes) is: $ _______________ per week / month / year

From (circle all that apply): Wages / Social Security disbursements / child support / other income
If other income not from wages; amount: $_______________ per week / month / year

Including myself I have _________ dependents.

Employee or Dependent of Employee of One Health Yes No **If yes, name of Employee______________________**

☐ *I wish to apply to the Sliding Fee Discount Program (please complete below)*. Signed: _____________________Date:__________

☐ *I **DO NOT** wish to apply to the Sliding Fee Discount Program*. Signed: __________________________________Date:__________

General Information

Do you have any health insurance? ❑ No ❑ Yes Type____

Have you applied for HMK/HMK+, Disability, SNAP or Unemployment within the last 3 months? _____________________

Household Members

Please list ALL members of the household.

Name	Relationship to Patient	Date of Birth	Employed at:	Full Time?
	SELF			Y/N
				Y/N
				Y/N
				Y/N
				Y/N
				Y/N
				Y/N
				Y/N

Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a member of the Sliding Fee Discount Program, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal. I understand that One Health is a federally-funded organization and that this self-declaration is subject to audit. **Self-declaration forms require supporting documentation of the income amounts and are ONLY valid for 30 days from acceptance date. To extend to one year, provide proof of income showing eligibility.**

Name of Patient (*printed*)	
Signature of PATIENT *or* GUARDIAN if patient is under 18	
Date	

Our Policy

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, sex, gender, sexual preference, age, or disability.

Thank you for completing this application form and for your interest in joining the Sliding Fee Discount Program.

Internal Use Only:

Application Received	Date: ___________________	OHE initials: __________
Incomplete-Request for Documents	Date: ___________________	OHE initials __________
Completed	Date: ____________________	OHE initials: __________

INCOME: FAMILY SIZE: ________________

Source___________________ Frequency____________ Amount $_________ Annual $_________
Source___________________ Frequency____________ Amount $_________ Annual $_________
Source___________________ Frequency____________ Amount $_________ Annual $_________
Source___________________ Frequency____________ Amount $_________ Annual $_________
TOTAL ANNUAL INCOME $____________
TOTAL MONTHLY INCOME $___________

Calculations:
For **Weekly** frequency, multiply by 52 to get Annual amount or by 4.33 to get Monthly.
For **Bi-Weekly** frequency, multiply by 26 to get Annual amount then divide by 12 to get Monthly.
For **Semi-Monthly** frequency, multiply by 24 to get Annual amount or by 2 to get Monthly
For **Monthly** frequency, multiply by 12 to get Annual amount.

Slide Category PC: _________ Beg. Date: _________________ End Date: ____________________
Slide Category FP: __________ Beg. Date: _________________ End Date: ___________________
Entered in EHR: Date: __________________ OHE Name: ___________________________
Letter Sent to Patient: Date: __________________ OHE Name: ___________________________
Preliminary FP Slide Category: ______________ Preliminary PC Slide Category: _______________

(DO NOT consider Social Security disbursements, child support, food stamps, TANF, SSI for Family Planning Services)
(DO NOT REQUIRE proof of income for Family Planning Services, however we can request this)

Verification Checklist:

______ Soft Credit Check for zero income ___________________ (date) ______________ (OHE Initials)

Credit check results:____

______ Offer CreditCare

______ Letters of eligibility from other government agency (follow-up for type)____________________________

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Interview Notes:____