Date Given: ____________ Date Received: ____________

Sliding Fee Application Patient Account #________________

HEAD OF HOUSEHOLD

Last Name:____________________ First Name:____________________ Middle Initial: ______ DOB:________

Mailing Address:____________________________ City/Town:______________State:___ Zip Code:________

Home Phone Number:(______)__________________Cell Phone (optional):(______)__________________

Please list birth names and dates of birth for all household members living at above address:

Names of Family/Household	Date Of Birth	Relationship to applicant
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

List additional family members on the back of application. **I decline the Sliding Fee Program:** ☐

I hereby certify that the above information is, to the best of my knowledge, true, complete and correct and is subject to verification by FHLC. I further agree to notify FHLC of any changes or corrections to this information within ten (10) days of any change or discovery of error and that failure to do so will result in my assuming responsibility for payment of full charges. I understand that eligibility lasts up to one year (if there are no changes in income or household size) and that I must re-qualify annually to determine my eligibility against changing federal standards. I am aware that this **application requires me to provide documentation within 30 days** of the signature date below for proof of income subject to verification and is based upon Federal Poverty Guidelines published annually by the Federal Government**. Sliding Fee payment for all services is due and payable at the time of service. I understand that Dental Special Service sliding fees must be paid in full before Dental work can proceed.** I understand that if I am referred to another provider or dentist, FHLC is not responsible for the cost of any referral visits. I understand that some laboratory tests will be billed through a third party, which I will be responsible for. I will speak with a FHLC Financial Counselor immediately if other payment arrangements are necessary due to an inability to pay.

X____ **Date:**____________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

***All documentation to determine eligibility must be returned to the office within 30 days of this application.**

Eligibility Information- For Office Use Only		
Household Income:	$	☐ Supporting Documentation (Or if no income, Self-Attestation Form required)
Application Level	A ☐ B ☐ C ☐ D ☐ E ☐	County:
Approved by FHLC Name:		Date:

FAMILY HEALTH
La Clinica

Date Given: ____________ Date Received: ____________

Continued Household Members

1.

2.

3.

4.

5.

6.