Sliding Fee Discount Program Membership Application

Household Members

Total number of people in your household who you share expenses with. This includes, but is not limited to yourself, spouses, boyfriend/ girlfriend, partners, other family members (aunts, uncles, parents) 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	$.	Interest/Dividend Income	$.	TANF	$.
Unemployment	$.	Rental/Investment 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.

Unemployed		No Income	

Agreement and Signature

All the 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 Discount, any false statements, omissions, or other misrepresentations made by me on this application may impact my patient status with One Health. 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 the acceptance date without supporting documentation for income amounts. To extend to one year, provide proof of income.**

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

One Health policy is to provide equal opportunities without regard to race, color, religion, national origin, sex, gender, sexual preference or orientation, age, or disability.

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Internal Use ONLY:

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

Income

Source	Frequency	Amount	Annual
Total			
Family Size			

Slide Category

	Category	Begin Date	End Date
30-Day Slide			
One Health Year Slide			
One Health Pharmacy Slide			

Complete

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

Additional notes

If proof of income received after initial application but within 30 days of original application. Please have patient sign below.

Patient or Witness Signature	**Date**
Staff Signature	**Date**

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