Mountain Valleys
HEALTH CENTERS

Sliding Fee Discount Program Application

Name:	**Date of Birth**

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes ___ No___ If yes, please list below:

Definition of Family Size: "Family size" shall be determined by considering, as a group, any related or nonrelated individuals living together whose production of income and consumption of goods are co-mingled. In addition, a single individual living alone shall be counted as one person for "family size" for purposes of the sliding fee. Please answer the following based on this definition of family size.

Family size: _____

***Besides Yourself,* Give Name and Date of Birth for all individuals included in the family size. Please indicate if they are a current patient by circling yes or no.**

Name	**Date of Birth**	**Current Patient**
		Yes or No
		Yes or No
		Yes or No
		Yes or No
		Yes or No
		Yes or No

How often do you get paid? ___ Weekly ___Bi-Weekly ___Twice Monthly ___Monthly

Definition of Income: "Income" is the total amount of earnings or support from whatever source derived.

For *Everyone* in your household, please list the gross income (before taxes) based on the aforementioned definition of income.

Wages:	**Public Assistance:**
Social Security/SSI:	**Rental Income:**
Unemployment:	**Interest Income:**
Disability/Workers Comp.:	**Education Assistance:**
Retirement/Pension:	**Child Support, Alimony:**
Self-Employment (Tax Return Required):	**Other (specify):**

- I acknowledge that I received and understand the MVHC Sliding Fee Discount Program Policy.
- I declare the above information is true and correct. I understand that this information will be kept in strict confidence. I understand if my income or "family size" should change, I am required to notify MVHC on my next visit to the health center. I understand that giving false information will result in the denial of discount benefits and that I will be responsible for the full fee and no longer eligible for the Sliding Fee Discount Program.

Applicant's Signature: _____ Date: _____

For Office Use Only

Date of Service: _____ Application received by: _____ Date: _____ W/I 30 Days Y N

Reviewed by: _____ Date _____ Supervisor Approval (for Self-Declaration) _____