BULLHOOK
Community Health Center

SLIDING FEE DISCOUNT APPLICATION

Applicant Information

Name: First, MI, Last	Social Security Number	Date of Birth	PT ACCT Number
Address:	City/State/Zip	Phone Number	Email Address

Please include information for yourself and all other individuals in the household for whom you are responsible for medical expenses regardless of insurance status: NOTE: see back side for definition for household If additional space is needed, continue on the back.**

NUMBER OF HOUSEHOLD MEMBERS: _____

Adult Name	DOB	Relationship	Insurance	Gross Income	Employed
		SELF	Y / N	$	Y / N
			Y / N	$	Y / N
			Y / N	$	Y / N

Child/Dependent Name	DOB	Ins?	Child/Dependent Name	DOB	Ins?
		Y / N			Y / N
		Y / N			Y / N
		Y / N			Y / N

Please include information/documentation for all adult family members who are employed. Income information must be provided within 2 days of your appointment with BCHC, otherwise services will be rendered without discount.

If your income is $0, how are you meeting your food, clothing, shelter, and transportation needs? This will be accomplished by filling out an income verification form with this application.

Employed Person	Company Name	Income (Pre-Tax)	Paid how often? (Check one)
		$	☐ Weekly ☐ 2 times/month ☐ Monthly ☐ Every 2 weeks
		$	☐ Weekly ☐ 2 times/month ☐ Monthly ☐ Every 2 weeks

Other Sources of Income:	Alimony $	SNAP/TANF $	Pension/Retirement $
Unemployment $	Disability $	Social Security $	Self-Employment $
Alimony $	Other $	Other $	Workers' Comp $

See back page for acceptable documentation

Nominal Fee by Department due at check-in (Note you will be responsible for the remainder of the bill per your slide agreement level)					
DEPARTMENT	**SLIDE A**	**SLIDE B**	**SLIDE C**	**SLIDE D**	**SLIDE E**
Medical	**$10.00**	**$20.00**	**$30.00**	**$40.00**	**$50.00**
Dental	**$50.00**	**$55.00**	**$60.00**	**$65.00**	**$70.00**
Behavioral Health	**$10.00**	**$11.00**	**$12.00**	**$13.00**	**$14.00**

Please read carefully before signing:

I agree to pay my nominal fee for each department due at the time of check-in for appointments with a provider, and I believe this nominal fee is reasonable for the services and discount provided through the Sliding Fee Scale Program. I also understand that any labs processed at Bullhook Community Health Center, Inc. will qualify for the SFS, but any lab work that is sent to an outside lab for processing may be my financial responsibility. By signing below, I agree that Bullhook Community Health Center, Inc. (BCHC) staff may contact each employer listed and/or other agencies to confirm my income. Within 2 days, I will give BCHC a copy of all information asked for, for all people in the home to see if I qualify for reduced fees. I will be asked to reapply for the program on an annual basis. **I agree to inform BCHC of changes to my income, family size, or insurance coverage.**

X_____ _____

Applicant Signature Date

_____/_____ _____

BCHC Staff Signature Printed Name Date

_____/_____ _____

BCHC Financial Counselor Signature Printed Name Date

For BCHC Use Only: Poverty Level:_____ Income:_____ Effective Date:_____ Expiration Date:_____

INCOME VERIFICATION INFORMATION

SOURCES OF INCOME	ACCEPTED DOCUMENTATION	SOURCES OF INCOME	ACCEPTED DOCUMENTATION
WAGES – Income received from employment	*Last Federal Income tax return, last **three** paystubs prior to the signature date on this application OR letter from employer stating average hours/wages paid for new employment*	**Public Assistance (TANF), Food Stamps/SNAP**	*Award Letter(s) listing amount received in the current year.*
		SSI/Disability	*Award Letter(s) listing amount received in the current year.*
		Workers' Compensation	*Benefit Award Letter for the current year*
Unemployment Compensation	*Benefit Award Letter for the current year*	**Alimony**	*Divorce Decree stating alimony received*
		401K draws	*Fill out income verification form or bring proof of draws*
Self-Employment Income	*Ledger or income and expenses for the current year or prior year income taxes*	**Retirement/Pension**	*Letter supplied by system administrator with monthly benefit amount for the current year*

BCHC requires proof of income or no income for those applying for the Sliding Fee Discount Program. If you and all family members in your household have no income at this time you must provide an income verification form for each member that would normally earn wages. This form explains how the family is supported and any unusual circumstances leading to zero or unreportable income.

Family Members continued:

Adult Name	DOB	Relationship	Insurance	Gross Income	Employed
		SELF	Y / N	$	Y / N
			Y / N	$	Y / N
			Y / N	$	Y / N

Child/Dependent Name	DOB	Ins?	Child/Dependent Name	DOB	Ins?
		Y / N			Y / N
		Y / N			Y / N
		Y / N			Y / N
		Y / N			Y / N

Definition of household:

Traditional family* – Note: Children 18 and older (unless going to college and fully supported by parent (s)) will not be listed on the slide. They are considered an adult and put on their own slide.

Non-traditional family* – those living as couples and their children under 18. Note: Children 18 and older (unless going to college and fully supported by parent (s)) will not be listed on the slide. They are considered an adult and put on their own slide.

***Note:** Grandparents living with either of the above situations would be on their own slide and not counted in the Traditional family or Non-traditional family.

Note: friends that are not in a relationship and sharing living quarters are not considered a household, each member living at that address is qualified to be on their own slide.