

SLIDING FEE APPLICATION (Optional for uninsured patients):

- 1 Proof of household income (last 30 days of pay stubs, prior year tax return, Social Security benefits)
- 2 Proof of social security number (if available)
- 3 Proof of address (current ID or light or gas utility bill)
- 4 Picture identification (birth certificate or state identification)
- 5 Proof of dependents / others in household (birth certificate, social security card, school attendance)
- 6 Minimum fee of \$20 for medical and / or minimum fee of \$55 for dental is required at the time of your appointment.

PATIENT INFORMATION:

Type of Visit: Initial _____ Review _____ Account # _____

PATIENT'S NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

SOCIAL SECURITY #: _____ - _____ - _____

TELEPHONE#: _____

Dependents (others in the household):

Please complete the following information for all dependents living in your household.

Name / Relationship	Date of Birth	Social Security #

Total number in household: _____

HOUSEHOLD INCOME VERIFICATION:

I DO NOT WISH TO DISCLOSE MY INCOME.

I AM NOT INTERESTED IN RECEIVING ANY DISCOUNTS.

Employed/___/Unemployed/___/ADC/___/Student/___/Disability/___/Other/___/

Filed Federal Taxes: Yes ___ No ___ If yes, what year? 20 ___

Place of Employment: _____

Yearly Gross Income (before taxes):\$ _____ Monthly Gross Income:\$ _____

Medicaid App Filed: Yes ___ No ___ / if no, why? Patient does not qualify / ___ / Patient declined/ ___/

General Assistance App Filed: Yes ___ No ___ / if no, why? Patient does not qualify / ___ / Patient declined/ ___/

PATIENT AGREEMENT:

By signing this form, I agree that all information given is a complete and accurate statement of my income and family size to date. I authorize Council Bluffs Community Health Center (CBCHC) to check all information presented. I agree to report any changes in income or family size to the CBCHC Case Manager immediately. I understand that any person who obtains or attempts to obtain by illegal means, services to which he/she is not entitled, may be charged under the applicable state and federal statutes.

Signature of Applicant: _____ Date: _____

Signature of Intake/Billing Representative: _____ Date: _____