Family Health Network of Central New York, Inc.
Sliding Fee Application

Patient's Name _____ **Today's Date**: _____

Date of Birth: _____ **Patient's Social Security #** _____

1. Income: List income for the family/household from:

Income Type/Document	Income Amount	Copies Provided
One-Month's Worth of Pay Stubs		
Employer Report Letter – Income Statement		
TANF Letter		
1040 Tax Form		
Self Employed Wage Documentation		
Statement of Social Security Benefits (SSI, SSDI, SSRI)		
Military Leave and Earnings Statement		
Foster Care statement from Social Services		
Current statement of Alimony		
Unemployment benefits		
Workers compensation benefits		
Local cash assistance benefits		
Pension or Annuities		
Cash amounts received or withdrawn from any source including savings, investments, trust accounts, or other resources readily available		
Patient Report Letter stating that he/she has no income		
Other: (Please list)		

2. Are you eligible for Medicaid? Yes ☐ No ☐ Don't Know ☐

3. Do you have any other Insurance? Yes ☐ No ☐ **If yes, what kind**? _____

If you do not have health insurance coverage, you may be eligible for health insurance through one of our programs. If eligible, the program in your county may pay for office visits, hospitalization, prescription, vision, and dental care. Family Health Network will be happy to assist you in receiving more information and/or applying for this program.
Would you like to be contacted by one of our enrollers?

Yes or No (circle one) County of Residence _____

Patient's Name ___________________________________ **Date of Birth**:______________________

4. **Family/Household Size:**) *List all persons within the same household (including dependents and/or partners)*

Name	Date of Birth	Relationship

I declare that the information contained in this application is true and accurate to the best of my knowledge. Failure to provide true and accurate information is fraud and may be subject to civil and/or criminal penalties. I understand that payment is due at the time of service.

Date: ______________________ Signature: ____

~ VERIFICATION OF INCOME REQUIRED ~

Please provide copies of all applicable forms of income listed above at the time of your application.

ATTENTION: If income verification is not provided on the day of application, you must provide it by the time of your next appointment in order for the sliding fee to be applied retroactively to your visit. Failure to provide income verification by your next appointment will result in the denial of your application and the cost of the visit will be solely your responsibility.

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FOR OFFICE USE ONLY:

Qualifies for: __________ % Discount __________ Ineligible

Date of determination: __________________

Signature of person making eligibility determination: ____