

**Sliding Fee Application**

The Alcona Health Centers is authorized by the Bureau of Primary Health Care to offer a Sliding payment scale, determined by family size and income, on the patient fees.

Those eligible for Medicaid and Medicare may apply directly to those programs.

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| **NAME OF APPLICANT AND HOUSEHOLD MEMBERS YOU ARE FINANCIALLY RESPONSIBLE FOR:** | **Established Patient of AHC?**  **Yes or No** | **DATE OF BIRTH** |
| **1. (Head of Household):** |  |  |
| **2.** |  |  |
| **3.** |  |  |
| **4.** |  |  |
| **5.** |  |  |
| **6.** |  |  |
| **7.** |  |  |
| **8.** |  |  |

**ALL INCOME VERIFICATION and necessary documents MUST BE TURNED IN WITH THE APPLICATION. We MUST have proof of income BEFORE we process your application.**

I UNDERSTAND ANY CHANGE IN INCOME MUST BE REPORTED WITHIN THIRTY (30) DAYS; and I attest

that the above statements are true and correct to the best of my knowledge.

Signature Date

Head of Household current phone number:

**For Staff use: Date Completed:**

|  |  |
| --- | --- |
| Proper income documentation received. Sliding fee calculation worksheet completed |  |
| Completed application information entered into EHS HHA and is a match. |  |
| Add to Spreadsheet for annual renewal reminder |  |
| Scanned to Sliding Fee Drive |  |

**REV. April 2018/Oct 2018 cp**