Sliding Fee Application- Self-Employed

Fill out this version of the form only if you or someone in your household is Self-Employed.

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.

NAME OF APPLICANT AND HOUSEHOLD MEMBERS YOU ARE FINANCIALLY RESPONSIBLE FOR:	Relationship to Head of Household	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 PM system and is a match.	
Add to Spreadsheet for annual renewal reminder	
Scan to Sliding Fee Drive	

REV. May 2020

alcona health center

Fill out this version of the form only if you or someone in your household is a Self-Employed.

CONTRACTED SELF-EMPLOYED INDIVIDUALS CAN PROVIDE COPIES OF CHECKS THEY HAVE RECEIVED (i.e. Working for a self-employed business and receiving a check from that entity) OR complete estimated personal monthly expenses below.

Those who are eligible for Medicaid or Medicare programs should apply directly to those programs.

Self-employed preferred income documentation is a copy of checks issued to yourself for weekly or bi-weekly payments. Only estimate if no other form of documentation is available.

MONTHLY PERSONAL **HOUSEHOLD** EXPENSES **NOT** RELATED TO YOUR BUSINESS

MORTGAGE OR RENT PAYMENT	**$**
UTILITIES	**$**
ELECTRIC	**$**
HEAT	**$**
WATER	**$**
PHONE	**$**
CABLE	**$**
TRASH REMOVAL	**$**
GROCERY EXPENSES	**$**
PROPERTY TAXES ON HOME	**$**
INSURANCE ON HOME	**$**
MEDICAL EXPENSES	**$**
CHILD CARE EXPENSES	**$**
CHILD SUPPORT PAYMENTS	**$**
MISCELLANEOUS (CLOTHING, PERSONAL CARE ITEMS)	**$**
TOTAL Estimated MONTHLY HOUSEHOLD EXPENSES	**$**

Head of Household Printed Name: _____

Head of Household Signature:__Date: __