



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.

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	