Community of Hope
Sliding Fee Scale Application

1. Patient Information:

Name: (First, middle initial, Last)	Date of Birth:		
Address:	City/State/Zip	Home Phone	Cell Phone:

2. Income Information: Please complete for all adult household members who have income and file taxes jointly. **PROOF OF INCOME** must be provided.

Employed Person	Company name	Gross Income	Paid how often?
		$	☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
		$	☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
Other sources of income:	Alimony $	TANF $	Pension/Retirement $
Child support $	Disability $	SSI $	Social Security $
Unemployment $	Other $	Other $	Other $

3. Household Information: List **ALL** individuals who are claimed as dependents on tax forms. ☐ Family application

Name	Date of Birth	Relationship	Status
1.			☐ COH patient
2.			☐ COH patient
3.			☐ COH patient
4.			☐ COH patient
5.			☐ COH patient
6.			☐ COH patient

4. Acknowledgment

By signing below, I acknowledge the information provided is true and accurate. I authorize Community of Hope to verify my income. I understand this proof of income must be provided to qualify for the sliding fee scale program. **If this proof of income is not received within 14 days, I understand I will be billed the full fee for the visit and will be responsible for full lab fees**. I further understand that I will be asked to reapply for the program each year in order to maintain eligibility. I will update the application if living circumstances including income, family members or insurance status changes. I have read the rules above and agree to them. I also understand that I am responsible for paying my fee at time of service, unless payment arrangements have been made in advance with the practice manager.

Applicant's signature: _____ Date: _____

Office Use Only:
Date: _____ **Staff Initials:** _____
☐ **Pending** **Notification Due Date:** _____
Slide Plan: ☐ **Slide A** ☐ **SlideB1** ☐ **SlideB2** ☐ **Slide B3** ☐ **Slide C** ☐ **Self Pay**
Notes: _____
_____
_____
_____
☐ Family application

Office Use Only:
Date: _____ **Staff Initials:** _____
☐ **Completed**
Slide Plan: ☐ **Slide A** ☐ **SlideB1** ☐ **SlideB2** ☐ **Slide B3** ☐ **Slide C** ☐ **Self Pay**
Notes: _____
_____
_____
_____
☐ Family application