OZARKS COMMUNITY HEALTH CENTER
MEDICAL • DENTAL • BEHAVIORAL HEALTH

SLIDING FEE APPLICATION

The Sliding Fee Scale Program offers reduced fees, based on a household's size and income. In order to be eligible for this program, the following application must be completed and submitted with the following information for all persons in the household:

- **Two Consecutive Months of Current Income Documentation for ALL adults living in the home** (See back for examples)
  or
- **Most Recent Tax Return**

NAME: _____ DATE: _____

ADDRESS: _____

CITY, STATE, ZIP:_____

PHONE:_____ DATE OF BIRTH:_____ SOCIAL SECURITY #_____

Information for ALL household members

NAME (LIST YOURSELF FIRST)	BIRTHDATE	INSURANCE	ACCT# (OFFICE USE ONLY)	MONTHLY INCOME AMOUNT

TOTAL # OF HOUSEHOLD MEMBERS_____

I declare the above information is true and accurate and I give Ozarks Community Health Center permission to investigate any information given in this application. I understand my information will be kept confiendtial and I am responsible for the minimum payment due at each visit. I am aware there may be additional charges related to laboratory and pathology tests that must be sent to outside laboratory facilities. I agree that I will be responsible for paying all charges, after the sliding fee discount has been applied, related to my visit. I understand that this application will expire on the date provided in my approval letter. After the expiration, I underatnd that I must re-apply. If my household income of size changes, I understand it is my responsibility to notify the health center. I understand that if found that I have falsified my income and/or household size, discounts will be reversed and I will be responsible for 100% of the charges.

SIGNATURE _____ DATE_____

OFFICE USE ONLY
Annnual Household Income_____ Household Size_____
SFS Level _____
Minimum Charge: Medical/Behavioral Health _____ Dental_____
Does not Qualify_____

OCHC Employee Signature _____
Effective Date _____Expiration Date _____

ADMIN APPROVAL

Comment_____

Signature_____

Dear Ozarks Community Health Center Patient:

Ozarks Community Health Center receives federal grant funding that allows the Health Center to offer a Sliding Fee Discount Program to individuals/patients/families who qualify, based on family size and income. If approved, you will be eligible to receive a discount on your services. Your minimum charge must be paid at the time of each visit.

To be eligible, you must submit:

1. **Completed Sliding Fee Scale Application**
   (including names birthdates for all household members)
2. **Most Recent Tax Return**
   Or
3. **Two consecutive months of Current Income Documentation for ALL adults living in the home**
   (which may include one or more of the following):

   - Two consecutive months of paycheck stubs for each working member of the household
   - Unemployment check stub(s) or determination forms
   - Social Security and/or Supplemental Security Income annual award statement
   - Worker's compensation award letter or check copies
   - Child Support/Alimony Statement
   - Interest Income Statement
   - Veteran's Benefits check copies or annual benefit statement
   - Public Assistance Monies
   - Railroad Retirement award letter
   - Retirement/pension award notice
   - Self-Employed individuals need to provide current income statement
   - Rent Received from land/buildings
   - If a household member is a college student submitting their own application, you must provide a current class schedule
   - We will not accept bank statements as proof of income