



New Horizon Family Health Services, Inc.
Sliding Fee Discount Program Application / Recertification

Patient Name: _____ **Date of Birth:** ___/___/_____

The data gathered on this form will only be used to get information about you and your household so that we can better meet your medical, behavioral health, and/or dental needs. **This information will not be used to withhold or deny services.**

You might be eligible for Medicaid or Medicare. This coverage does not affect your eligibility for the sliding fee.
Would you like to apply or re-apply for Medicaid or Medicare today? YES NO N/A

The Sliding Fee Discount Program eligibility and classification is determined by two factors:

- annual household income
- household size

Your household includes yourself, your spouse/partner, all dependents, and others living in your home.

Please list ALL household members, including yourself, below.					
Name	Age	Relationship	Name	Age	Relationship
		Self			

1. Please present your eligible income documents for **ALL** household members.
2. Read the following statement and sign below.

I certify that the above information is correct to the best of my knowledge. I hereby give permission to New Horizon Family Health Services, Inc. to verify all the above information. If I have a change in my financial status, I will notify the center. In addition, I certify that I have presented my proof of income for all household members and listed all household members above.

Patient Signature (or responsible party): _____ **Date:** _____
Relationship: _____



STAFF ONLY BELOW

Total Number of Household Members (listed in chart above): _____

A	B	C	D
Income Type	<u>Gross Amount</u>	Frequency (Circle One)	Income
Work Wages	\$	Wk (Bx52) / BiWk (Bx26) / SemiMth (Bx24) / Mth (Bx12) / Annual (B)	\$
Cash Wages	\$	Wk (Bx52) / BiWk (Bx26) / SemiMth (Bx24) / Mth (Bx12) / Annual (B)	\$
Disability	\$	Wk (Bx52) / BiWk (Bx26) / SemiMth (Bx24) / Mth (Bx12) / Annual (B)	\$
Social Security	\$	Wk (Bx52) / BiWk (Bx26) / SemiMth (Bx24) / Mth (Bx12) / Annual (B)	\$
Unemployment	\$	Wk (Bx52) / BiWk (Bx26) / SemiMth (Bx24) / Mth (Bx12) / Annual (B)	\$
Worker's Comp	\$	Wk (Bx52) / BiWk (Bx26) / SemiMth (Bx24) / Mth (Bx12) / Annual (B)	\$
Other Income	\$	Wk (Bx52) / BiWk (Bx26) / SemiMth (Bx24) / Mth (Bx12) / Annual (B)	\$
TOTAL ANNUAL INCOME (Add Column D)			\$

Signature states that I have verified income documentation.

Staff Signature: _____ Date: _____