FAMILY
Health Source

SLIDING FEE SCHEDULE (SFS) DISCOUNT - NEEDED DOCUMENTS

TARIFA DE DESCUENTOS - DOCUMENTOS QUE HACEN FALTA

You may qualify for our Sliding Fee Schedule Program (discount) for your medical Services and labs at our clinics. This program is made available to provide care for people who otherwise may be unable to see a primary care provider. (Puede que puedan calificar para nuestro Programa de Escala de Tarifa (descuento) para los servicios médicos y laboratorios en nuestras clínicas.)

APPLICANT(S): (SOLICITANTE(S)	❑COMPLETED SLIDING FEE APPLICATION (APLICACIÓN PARA EL PROGAMA DE DESCUENTO) AND ❑PICTURE ID (IDENTIFICACION CON FOTO) AND ❑LAST 4 PAYSTUBS (last 2 if paid bi-weekly) (4 TALONARIOS DE CHEQUE (solo 2 si bi-semanal) OR ❑LAST TAX RETURN (ULTIMOS IMPUESTOS) OR ❑PROOF OF ANY OTHER INCOME, LIKE SOCIAL SECURITY, VETERANS BENEFIT, PENSION, IRA, CHILD SUPPORT, DISABILITY, ETC. (PRUEBA DE OTROS INGRESOS COMO SEGURO SOCIAL, BENEFICIOS DE VETERANO, PENSION, IRA, MANUTENCION DE MENORES, ETC) AND ❑NOTARIZED *VERIFICATION OF SUPPORT* (form attached) (VERIFICACION DE APOYO NOTARIZADA)

FOR SPOUSE: (ESPOSO(A)	❑LAST 4 PAYSTUBS (last 2 if paid bi-weekly) (4 TALONARIOS DE CHEQUE (solo 2 si bi-semanal) OR ❑LAST TAX RETURN (ULTIMOS IMPUESTOS) OR ❑PROOF OF ANY OTHER INCOME, LIKE SOCIAL SECURITY, VETERANS BENEFIT, PENSION, IRA, CHILD SUPPORT, DISABILITY, ETC. (PRUEBA DE OTROS INGRESOS COMO SEGURO SOCIAL, BENEFICIOS DE VETERANO, PENSION, IRA, CHILD SUPPORT, ETC)
FOR DEPENDENT(S): (DEPENDIENTE(S)	❑BIRTH CERTIFICATE OR PROOF OF GUARDIANSHIP (ACTA DE NACIMIENTO O PRUEBA QUE TIENE CUSTODIA LEGAL) IF CHILD NOT LISTED ON TAX RETURN OR NO TAX RETURN PROVIDED OR ❑FOR WORKING DEPENDENT, LAST 4 PAYSTUBS (PARA DEPENDIENTES QUE TRABAJAN, ULTIMOS 4 TALONES DE CHEQUES) OR ❑IF ADULT DEPENDENT, WITHOUT INCOME, NOTARIZED VERIF. OF SUPPORT (form attached) (SI SON ADULTOS Y NO TRABAJAN, VERIFICACION DE APOYO NOTARIZADA) AND ❑PROOF OF ANY INCOME, SUCH AS SSI, DISABILTIY, CHILD SUPPORT, ETC (PRUEBA DE CUALQUIER INGRESO)

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CHART#:_____

Sliding Fee Schedule (SFS) Discount Program Application

NAME OF APPLICANT (NOMBRE DEL SOLICITANTE)			DATE (FECHA)	
STREET (CALLE) ❑Own❑Rent❑Live w/someone❑Homeless	CITY (CUIDAD)	STATE (ESTADO)	ZIP (CODIGO)	PHONE (TELEFONO) ❑Home ❑Cellular

Please list spouse and dependents (Por favor liste su cónyuge y dependientes)

Name (Nombre)	**DOB (Fecha de Nacimiento)**	**Name (Nombre)**	**DOB (Fecha de Nacimiento)**
NAME OF APPLICANT (NOMBRE DEL SOLICITANTE) ❑ Married ❑Separated ❑Divorced ❑Single ❑Widow		**DEPENDENT** (DEPENDIENTE)	
SPOUSE (CONYUGE/ESPOSA(O)		**DEPENDENT** (DEPENDIENTE)	
DEPENDENT (DEPENDIENTE)		**DEPENDENT** (DEPENDIENTE)	
DEPENDENT (DEPENDIENTE)		**DEPENDENT** (DEPENDIENTE)	

Annual Household Income (Ingreso Anual del Hogar)

Source (Fuente) **Circle which ones apply (Circule cuales aplican)**	**Applicant (Solicitante)**	**Spouse (Conyuge)**	**Other (Otro)**	**Total**
Gross job wages, tips, etc. (Salario bruto, propina, etc.)	$	$	$	$
Income from business, self-employment, and dependents (Ingresos de negocio, cuenta propia y dependientes)				
Unemployment, workers' comp, Social Security, SSI, veterans' payments, survivor benefits, pension or retirement income (Desempleo, workers' comp, Seguro Social, SSI, beneficios de veterano, pensión o jubilación)				
Interest, dividends, rents, royalties, income from estates, trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources (Intereses, dividendos, alquileres, renta de propiedades, alimony y otras) fuentes diversas)				
Total Annual Income (Total Ingresos anuales)	**Total Annually:** **$**	**Total Annually:** **$**	**Total Annually:** **$**	**Total Annually:** **$**

NOTE: Copies of tax returns, pay stubs, or other information verifying income will be required before a discount is approved. I certify that the family size and income information shown above is correct.

Applicant Name (Print): _____ _____

Applicant Signature: _____ Date:

Scan to Patient Chart under Slide Fee

Revised: 4/25/2018 By Director of Revenue

Office Use Only

Applicant's Name: _____ Date of Birth: _____

Approved Discount: ❑Slide A ❑Slide B ❑Slide C ❑Slide D ❑Slide E DENIED: ❑Full Pay PRIOR SLIDE?_____

Name of Staff: _____ REASON DENIED: _____

Approved by Signature: _____Date Approved: _____

Family Health Source Verification Checklist		Yes	No
Identification:	Driver's license, Passport, Farmworkers ID or other picture ID		
Prior year tax return:	Tax return provided for Year: _____		
If Adult Dependents:	Need proof of their income or Notarized Verification of Support		
Income:	4 Recent Paystubs if paid weekly or 2 Recent Paystubs if paid bi-weekly		
	Unemployment, Workers Comp, Social Security, SSI, veteran's payment, survivor's benefit, pension/retirement, IRA, etc.		
	Interest, dividends, rental income, royalties, income from estates, trust, alimony, child support, etc.		
If Homeless:	Homeless Shelter Verification and Notarized Verification of Support by person providing support		
If No Social Security #:	Two forms of ID		
	If claiming dependents, we need birth certificates		
If no income:	Notarized Verification of Support by person providing support		
If Self-Employed:	Need Last tax return or Notarized Verification Income Form		
Third Party payor:	Appointment made with enabling services		
	WVHA Health Card Program application given		

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VERIFICATION OF INCOME FORM (VERIFICACIÓN DE INGRESO)

PATIENT SECTION (SECCION DEL PACIENTE):

Please choose all options that apply to you *(Por favor, elija todas las opciones que se apliquen a usted).*

PATIENT'S NAME (NOMBRE DEL PACIENTE):_____ DOB(FECHA NACIMIENTO):_____

ADDRESS(DIRECCIÓN):_____ HOW LONG(CUÁNTO TIEMPO)?____YR/MO

- ❑ I declare that I am presently unemployed and have been unemployed for _____ months. I have/have not applied for unemployment benefits (date applied for benefits_____)
  Declaro que actualmente estoy desempleado y he estado desempleado durante _____ meses. He/no he solicitado beneficios de desempleo (fecha de solicitud de beneficios_____)

- ❑ I declare that I am presently self-employed and receive $_____ per month for the last _____ months and did not file a tax return last year.
  Declaro que actualmente trabajo por cuenta propia, y que recibí $ _____ por mes durante los últimos _____ meses y que no presenté declaración de impuestos el año pasado.

- ❑ I declare that my food and living expenses are provided by (Name and phone number) _____ in the amount of $_____ per month. (Supporter section must be completed)
  Declaro que mi alimentación y mis gastos de vida son proporcionados por (Nombre y número de teléfono) _____ por la cantidad de $ _____ por mes. (La sección de apoyo debe completarse)

PATIENT SIGNATURE (FIRMA DEL PACIENTE): _____DATE(FECHA):_____

SUPPORTER SECTION (SECCIÓN DE QUIEN LE DA EL APOYO)

Supporter's Name (Nombre del apoyador): _____ Phone# (# tel): _____

Address Dirección):_____

I have been providing food and living expenses to, _____, in the amount of $_____ per month. By signing this, I understand under penalty of perjury that any misrepresentation of the information that I provide to NEFHS, Inc DBA Family Health Source is federal fraud punishable by an applicable law.

He estado proporcionando alimentos y gastos de vida a, _____, en la cantidad de $ _____ por mes. Al firmar esto, entiendo bajo pena de perjurio que cualquier mala representación de la información que proporciono a NEFHS, Inc. DBA Family Health Source es un fraude federal punible por las leyes aplicables.

SUPPORTER SIGNATURE (FIRMA DEL APOYANTE):_____DATE(FECHA):_____

STATE OF FLORIDA, COUNTY OF VOLUSIA (Notary Seal)

Sworn before me this _____ day of _____, 20___, by _____

Signature of Notary Public-State of Florida: _____

Name of Notary typed, printed, or stamped:_____

_____Personally Known OR _____Produce Identification Type of ID:_____