HEALTH CENTERS DETROIT FOUNDATION

Sliding Fee Scale Discount Program Application and Eligibility Form

Date: _____

Patient Name: _____

Number in Household: _____

Address: _____

City, State and Zip Code: _____

Proof of Income Verification- The following list are types of proof that can be used for verification

- Paycheck stubs (minimum of one month, preferably three months)
- Statement from employer as to proof of wages (when check stubs are not used)
- Statement from unemployment services
- Statement of income determination from the Department of Housing
- Annual W-2 wage statements from all income sources
- Statement for SSI or food stamps

In the absence of the above, patients may produce other proofs of income including tax return

How often do you receive your income?
Daily ___ Weekly ___ Bi-Weekly ___ Bi-Monthly ___ Monthly ___

Has your housing changed dramatically in the past year? Yes ____ No ___
If so how? _____

_____

1. Household Income Wages: _____ $

2. Unemployment: _____ $

3. Public Assistance: _____ $

4. Other: _____ $

Total Income: (add lines 1 through 4) _____ $

Affidavit of Income (Please check all that apply)

☐ I am providing this information with documentation verifying income.

☐ **I have no proof of income** and understand that initial services are being provided at the minimum nominal required payment. If I do not provide proof of income information, I will be charged/billed the full fee for the initial visit, as well as, future services.

☐ **I have no income** and this affidavit is signed by my (guarantor) family member or friend stating that I am unemployed, have no source of income, and that the family member or friend is providing financial support to you and your family.

☐ I am homeless.

I certify that the above information is true and accurate to the best of my knowledge. I agree to provide annual updates to this documentation upon request. Further, I will make application to any assistance (Medicaid, Medicare, etc.) which may be available for payment of my health care charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the provider the amount recovered for health care charges.

Patient Signature: _____ Date:_____

If signing on behalf of the applicant: all information in this application is true to the best of my knowledge.

Signature of applicant: _____ Date: _____

TO PROTECT YOUR PRIVACY THE INFORMATION ON THIS FORM IS NEVER SHARED WITH ANY PRIVATE BUSINESSES OR ORGANIZATIONS