Family Christian Health Center

31 W. 155th Street, Harvey IL 60426 | Ph: 708-596-5177, Fx: 708-339-3583

Sliding Fee Application

I. Applicant Name: _____DOB:_____

II. Household* Size Information *(*Household members include those persons living in the same home who are related by birth, marriage, registered domestic partnership, or adoption.)*

Please list below **all members** of your household, including yourself.

	Name	Relationship	DOB		Name	Relationship	DOB
1.		*self*		5.			
2.				6.			
3.				7.			
4.				8.			

III. Household* Income Information

Please list **below all sources of income of all adult members of** your household, **including** yourself. Adults are considered those persons 18-years and older. Please attach to this application verification of each source. See Appendix A. for examples of documents acceptable as proof of **income.**

Name	Relationship	Source of Income (see Appendix A. for examples)	Amount Received	Frequency (i.e. weekly, biweekly, monthly, yearly)	*FOR OFFICE USE ONLY:* Total
	self				*FOR OFFICE USE ONLY*
					FOR OFFICE USE ONLY
					FOR OFFICE USE ONLY
					FOR OFFICE USE ONLY
					FOR OFFICE USE ONLY

I certify that all of the information in all above sections is true. I acknowledge if any misrepresentation is made I will be responsible for all charges related to my services provided:

Date **Applicant Name** **Signature** **Relationship (if not applicant)**

FOR OFFICE USE ONLY:

Verification Checklist:

Complete Application	**Yes**	
Verification(s) of Income	**Yes**	
Proof of Medicaid/Medicare denial	**Yes**	**N/A**
Proof of Identity	**Yes**	**N/A: Renewal application; ID proof already on file**

Application Approval/Denial:

Household Size: **Monthly Household Income:** **FPL:** **FPL Range: 0-99% 100-200% 201% +**

Eligible for Sliding Scale? **Yes** **No** ***If yes, level:*** **Nominal** **100-200%** **Staff Initials:** **Date:**

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Appendix A

Source of Income: Examples

All of the below count as income for Family Christian Health Center's Sliding Fee Program, if received by any adult member of your household.

Alimony	**Gift income**	**Social Security Administration Payments (SSA)**
Worker's Compensation	**Grants/scholarships**	**State Disability Insurance (SDI)**
Cash income	**Interest income**	**Unemployment Benefits**
Disability	**Rental Income**	**Veteran's Benefits**
Earnings from a job	**Retirement, Survivors, or Disability Insurance**	
General Assistance (GA)	**Self-employment**	

Verification of Income: Examples

All of the below may be used to verify income for Family Christian Health Center's Sliding FeeProgram. All sources of income must be verified; if none of the below are available, please speak with the Front Desk.

Affidavit (signed) of Gift Income/Support	**Checks Received (copies)**	**Rental Income Worksheet**
Award letter (for programs like GA, grants, scholarships, SDI, SSA, unemployment)	**Letter from & signed by employer**	**Tax Return: Complete, 1040, 1040A, and/or 1040E2**
Bank statement with Direct Deposit	**Pay stubs**	
Benefits checks/statements (for programs like GA, grants, scholarships, SDI, SSA, unemployment)	**Profit and Loss Statement**	