Community Health Services
Your Partners for Better Health

Valid to March 31, 2027

SLIDING FEE SCALE APPLICATION

PERSONAL INFORMATION

LAST NAME | FIRST NAME

DATE OF BIRTH | SOCIAL SECURITY NUMBER

ADDRESS – CITY, STATE & ZIP

HOME PHONE NUMBER | CELL PHONE NUMBER

HOUSEHOLD INFORMATION

NAME OF SPOUSE

DATE OF BIRTH | SOCIAL SECURITY NUMBER

LIST DEPENDENTS CLAIMED ON YOUR TAX RETURN

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP
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PROOF OF INCOME

You must bring proof of income. ☐ Most recent tax return ☐ Form 4506-T

- I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge.
- I understand a nominal fee of $35.00 will be requested at the time of each medical office visit, a $40.00 nominal fee will be requested at the time of each dental office visit, and a $20.00 nominal fee for each behavioral health office visit, and that I will be responsible for any remaining balance.
- Sliding fee adjustments will go back 60 days from the date the application is approved.

APPLICANT'S SIGNATURE | DATE

Eligibility Information – For Office Use Only Annual Gross Income $_____ # of Dependents _____

_____ Application Approved ☐ Nominal Fee Only ☐ 20% Payment ☐ 40% Payment ☐ 60% Payment ☐ 80% Payment

_____ Application Denied - RESPONSIBLE FOR 100% OF BILL

PROCESSED BY | DATE