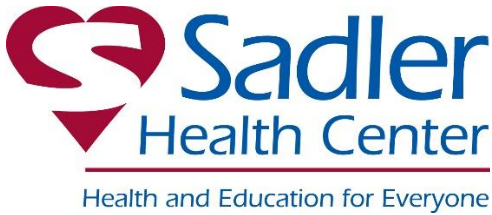

Sliding Fee Discount Program Application

PLEASE LIST ALL MEMBERS IN YOUR HOUSEHOLD

Definition of Household: A household consists of all the persons who occupy a house or apartment. Adult children living at home who are no longer dependent are considered a separate household. Roommates who share living arrangements but are not tied to one another through marriage, children or similar relationship are considered separate households. Those living with a friend or relative during a time of need are also considered a separate household.

First Name / Last Name Of all household members	**Relation**	**Insurance Name (if active)**	**INCOME** Check One ☐ Monthly ☐ Annual	**Date of Birth**	*Sadler Health Staff Use Only* **Account #**
	Self		$		
	Spouse		$		
	Child		$		
	Child		$		
	Child		$		
	Child		$		
Additional household members can be listed on reverse.					

PROOF OF INCOME MUST BE PROVIDED. A list of required documents is provided on reverse.
You will be charged our FULL FEES until this application is complete with supporting documentation.
Effective Date of eligible slide will not take effect more than 30 days prior to receipt of completed application including proof of income.

If declaring $0 income, please explain how you are able to sustain shelter and food:

Household Street Address	**Apt.**	**City**	**State**	**Zip**
Home Phone:	**Cell Phone:**			

I was screened for health insurance eligibility and have been advised… (Check one below)

- ☐ I may be eligible and should apply for Chip/ Medical Assistance/ HealthCare.gov coverage.
- ☐ I am not eligible to apply for Chip/ Medical Assistance/ HealthCare.gov coverage.
- ☐ I currently have affordable health insurance coverage: Chip, Medicaid, Medicare, Marketplace, or commercial.

I hereby certify that the information provided in this application is true and complete. I understand that willful falsification and/or omission of information contained in this application will result in denial of financial assistance. I understand the information provided will be checked for accuracy and verified.

______________________________ ________________________

Patient Signature **Date**

If you have questions regarding this application you may contact one of our Patient Eligibility Specialists by calling 717-960-4395.

Income Documents REQUIRED if Applicable

- Pay stubs or letter from employer (on letterhead) listing wages before taxes for last 30 days.
- Unemployment Compensation Determination Letter
- Award letters (SSI or SSD) *REQUIRED IF APPLICABLE
- Court documents, or bank statements showing deposits of child or alimony payments
- Documentation of other sources of income
- Most recent tax return if self-employed

Preferred but NOT required

- *Checking and savings account statements from the bank showing the last full 30 days of activity (Individual and Business). Statement must show bank and account name.*

Additional Household Members

First Name / Last Name **Of all household members**	**Relation**	**Insurance Name (if active)**	**INCOME** **Check One** ☐ **Monthly** ☐ **Annual**	**Date of Birth**	***SHCC Office Use Only*** **Account #**
	Child		$		
	Child		$		
	Child		$		
	Child		$		
	Child		$		
	Child		$		
	Child		$		
	Child		$		

FOR OFFICE USE ONLY

Calculation Notes:

Family Size:	**Gross Household Income Amount: $**	**Check One:** ☐ **Monthly** ☐ **Annual**	
Slide Level:	**Discounted Fee/visit: $**	**Effective:**	**Expires:**
Results provided via: (circle one) **In Person Letter Call** ***Initial Application or Change in level Only***		**Date:**	**No Change**

Additional Notes:

Processed by: **Date:**