



**Sliding Fee Discount Program Application 2017**  
**Acknowledgement of Receipt of the Sliding Fee Discount Program Policy**

**I have received a copy of the 2017 Sliding Fee Discount Program Policy and I agree to abide by the Program requirements.**  
**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**Name: \_\_\_\_\_**

**Date of Birth: \_\_\_\_\_**

**Do you have any type of insurance that will cover all or a portion of your medical expense? Yes \_\_\_ No \_\_\_ If yes, please list below:**  
 \_\_\_\_\_

**Definition of Family Size:** "Family size" shall be determined by considering, as a group, any related or nonrelated individuals living together whose production of income and consumption of goods are co-mingled. In addition, a single individual living alone shall be counted as one person for "family size" for purposes of the sliding fee. Please answer the following based on this definition of family size.

**Family size:** \_\_\_\_\_

**Besides Yourself, Give Name and Date of Birth for all individuals included in the family size.**

<b>Name:</b>	<b>Date of Birth:</b>
<b>Name:</b>	<b>Date of Birth:</b>
<b>Name:</b>	<b>Date of Birth:</b>
<b>Name:</b>	<b>Date of Birth:</b>
<b>Name:</b>	<b>Date of Birth:</b>
<b>Name:</b>	<b>Date of Birth:</b>

**How often do you get paid? \_\_\_ Weekly \_\_\_ Bi-Weekly \_\_\_ Twice Monthly \_\_\_ Monthly**

**Definition of Income:** Income is the total amount of annual money income each individual received before payments for income taxes, social security, Medicare deductions, etc. Please answer the following based on this definition of income.

**For Everyone in your household, please list the gross income (before taxes) based on the aforementioned definition of income.**

<b>Wages:</b>	<b>Public Assistance:</b>
<b>Social Security/SSI:</b>	<b>Rental Income:</b>
<b>Unemployment:</b>	<b>Interest Income:</b>
<b>Disability/Workers Comp.:</b>	<b>Education Assistance:</b>
<b>Retirement/Pension:</b>	<b>Child Support, Alimony:</b>
<b>Self-Employment (Tax Return Required):</b>	<b>Other (specify):</b>

I declare under penalty of perjury that the above information is true and correct and I give Mountain Valleys Health Centers (MVHC) permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income or "family size" should change, I am required to notify MVHC on my next visit to the health center. I understand that giving false information will result in the denial of discount benefits and that I will be responsible for the full fee and no longer eligible for the Sliding Fee Discount Program.

**Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**For Office Use Only**

<b>Family Size</b> _____	<b>Total Annual Income</b> _____	<b>Sliding Fee Category</b> _____	<b>Chart #</b> _____
<b>Reviewed by</b> _____	<b>Date</b> _____	<b>Effective Date</b> _____	<b>Expires: 12/31/2017</b>

**Notice of Nondiscrimination**

MVHC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**Translation Services**

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Por favor, háganos saber cuándo haga la cita que se necesita ayuda con el idioma.

注意：如果您说中文，您可以免费获得语言协助服务。请在预约时告知我们您需要语言协助