# SLIDING FEE DISCOUNT PROGRAM APPLICATION

1. Are you claimed as a dependent on a relative's taxes? ☐ Yes ☐ No Comment: _____
   a. ***Note: If you are claimed as a dependent on a relative's income taxes, you cannot apply, the person claiming you must apply, using their information.***

2. Who is employed in the household? ☐ Self ☐ Spouse ☐ Both

3. Have you applied for Medicaid or had Medicaid coverage in the past year? ☐ Yes ☐ No Comment: _____

   a. Are you under age 21, pregnant, or the primary caretaker of a child living in your home under the age of 19? ☐ Yes ☐ No Comment: _____

4. Are you age 65 or older?

   a. Have you applied for Medicare? ☐ Yes ☐ No Comment: _____
   b. Are you receiving Social Security Disability?
   c. Have you recently been disabled or will you be disabled for 12 months?

5. Are you legally blind? ☐ Yes ☐ No Comment: _____

6. Are you a veteran?
   a. Have you applied for VA benefits? ☐ Yes ☐ No Comment: _____

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Please list family members who live in your household and are claimed as dependents for tax purposes

| HOUSEHOLD – Please list family members who live in your household and are claimed as dependents for tax purposes. | | |
|---|---|---|
| **NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER** |
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Total Household Size _____ Total Family Income $_____

I HEREBY CERTIFY THAT THE INFORMATION SUBMITTED IS TRUE TO THE BEST OF MY KNOWLEDGE. I give permission to Advance Community Health to contact any individual who may have information regarding my eligibility. I declare, under penalty of perjury, that the information on this form, my Federal Income Tax Return, and the accompanying documentation submitted with this application, is true, correct and complete. If it is determined that any of the information provided is inaccurate or if I fail to immediately notify Advance Community Health of any changes, I understand that I shall be removed from the Sliding Fee Discount Program, and that I shall be responsible for all charges retroactive to the date the information was found to be inaccurate, and that I may no longer be able to receive discounted care from Advance Community Health.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Patient Name/ | Patient or Guardian Signature | Date |
| _____ | _____ | _____ |
| ACH Employee Witness | Employee Signature | Date |
| _____ | _____ | _____ |
| ACH Employee 2nd Witness | Employee Signature | Date |