Finger Lakes COMMUNITY HEALTH
Taking the time to care.

Sliding Fee Discount Program Application

First Name	MI	Last Name	DOB (MM/DD/YY)	Today's Date

Current Age		☐ Married ☐ Not Married	☐ Minor (12 to 18 years of age) applying for Family Planning Funded Discount only

List below all household members and household income (including yourself):

Name	DOB (MM/DD/YY)	Relationship	Monthly Income
		Self	

If you are reporting no income, you must describe your current means of support and/or living situation:

DECLINED (by initialing and dating, I understand that I am not eligible for any sliding fee discounts.) _____ _____
Initials Date

I authorize Finger Lakes Community Health Staff to discuss my patient account balance in my absence with _____ whose phone number is _____.

I declare, under penalty of perjury, that the information I have given on this form is true, correct and complete. I understand that the giving of false information may make me ineligible for discounted services.

Applicant Signature: _____ **Date:** _____

Office Use Only

Total Household Members: _____ Total Monthly Household Income: _____ Total Monthly Family Planning Funded Income:_____

Did you assign the General Slide to the patient account? ☐ Yes ☐ No

Did you note the Family Planning Funded in the Income Section? ☐ Yes ☐ No ☐ N/A

POI Provided:

☐ Yes (Expires 365 days) Termination Date: _____

☐ No Termination Date: _____

☐ No (Expires in 365 days) The patient has barriers that do not allow them to obtain the necessary proof income and doing so would place barriers to care and/or financial hardship. I have, as best as possible determined that the stated income is correct, and that the number of people listed as household members is true to the best of my knowledge. Termination Date: _____

Staff Signature: _____ **Date:** _____