CrescentCare
A Partnership for Life

Sliding Fee Scale Discount Application

Patient Name	Patient Date of Birth
Patient Address	Patient Social Security Number
Patient City, State, Zip	Patient Phone Number
Name of Head of Household	Place of Employment

Street	
City, State, Zip	
Phone Number	
Social Security Number	

PLEASE LIST SPOUSE AND DEPENDANTS UNDER THE AGE OF 18

Relationship	Name	Date of Birth
SELF		
SPOUSE/PARTNER		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		

Income Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
From business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veteran's payments, survivor benefits, pension or retirement				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
TOTAL INCOME				

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By signing this form, I attest that my family size and income provided above is true and correct to the best of my knowledge. I further understand that providing false information may mean I cannot receive care here. I give CrescentCare permission to investigate any information on this application including running a credit report. I understand that if my income should change I will notify CrescentCare staff at my next visit. I hereby acknowledge that I am applying for assistance under a HRSA-funded program and that Title 18 Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements.

_____ _____

Signature ***Date***

CrescentCare's sliding fee discount is available to patients whose incomes and household family size fall at or below 200% of the Federal Poverty Guidelines. Sliding fee means that costs change according to the patient's income and household size. At CrescentCare household or family size is all individuals who define and present themselves as a family for services, regardless of actual or perceived marital status, sexual orientation, or gender identity. A family may be a group of related or unrelated persons who share living arrangements, expenses and income. Non-relatives, such as housemates, do not count as members of a family.

To qualify for the sliding fee scale discount program, you must provide proof of income within 30 calendar days. We accept the following documentation as proof of income – check stubs, SSI/SSDI award letter, food stamps letter, letter from an employer, proof of Medicaid, personal income tax form, or proof of acceptance on a subsidized housing program like Section 8 or permanent supportive housing. Other documentation will be accepted on a case-by-case basis. If you do not provide this information after 30 calendar days you will be charged the full amount of the visit.

CrescentCare Use Only

Patient Name	
Approved Discount	
Approved By	
Date Approved	