28 Executive Drive, Norwalk, Ohio 44857 | P: 419-668-1652 EXT. 241 | F: 419-668-5423
392 East Howard Street, Willard, Ohio 44890 | P: 419-935-0213 | F: 419-935-0242

Initial Application? _____ Year _____	Renewal? _____ Year _____

Sliding Fee Scale Application and Payment Authorization

Patient Name (Please Print)_____ Date of Birth ____/____/_____

Social Security # _____ Parent/Guardian Name (Please Print) _____

We request household income for all patients to provide the opportunity to qualify for the sliding fee scale for out-of-pocket costs associated with services provided. If you choose not to provide this information, you understand that you will be responsible for 100% of costs not covered by your insurance.

☐ Bill my insurance (Please provide your card(s) to the clerk). I understand that I am responsible for co-pays, deductibles, and coinsurance as required by my insurance plan.

☐ I choose not to provide my household income information and understand that I will be responsible for 100% of costs not covered by insurance.

☐ I would like to apply for reduced fees. (**ANYONE CAN APPLY-WITH OR WITHOUT INSURANCE**)

- ☐ I am 17 years old or younger and need confidential services. Please calculate my fees based on my income only.
- ☐ I am in college or vocational school and receive the following **funds for my living expenses:**
  Scholarships/loans $_____ Parents $ _____Other $ _____ per ☐ quarter ☐ semester
  I attend _____ number of quarters/semesters a year

Number of people supported by family income (household size) _____
Total amount of income before taxes for the household is: $_____per ☐week ☐month ☐ year

<u>*Signature Required on back page*</u>

It is the policy of the Health Center of Huron County (HCHC) to provide essential medical, mental health, behavioral health, and dental services regardless of the patient's ability to pay. If qualified, a discount may be applied to co-payment, co-insurance, and/or deductible balances that are greater than the nominal fee. To qualify for the "sliding fee scale", you must provide proof of household income and the household occupancy. The current nominal fee is $30 for medical services (*not applicable for immunization-only visits).*

*Income includes all earned income/wages and unearned income including wages, salaries, tips, long-term disability, self-employment, unemployment, social security, pensions/retirement, and worker's compensation.

SLIDING FEE DISCOUNT AGREEMENT: I understand and agree that some services rendered are based on my ability to pay. If payment for other services is determined by and based on a sliding fee scale, I understand that I am responsible for my

For staff: Sliding Fee Scale ☐ 0% ☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐ 100% **(0%= $30.00)**
Verified by: (Staff Signature) _____ Date: _____

share of the cost of services rendered at time of service and that failure to provide "proof of income" will result in me being charged 100% of the cost of services received and/or provided.

I agree, whether as a patient, agent, guardian, relative, or representative, that in consideration of the services rendered, I hereby individually guarantee and obligate myself to pay the account of the HCHC in full. I further understand that failure to comply with my responsibilities for payment of services rendered may result in suspension of appointments.

I certify that the family size and income information shown above are correct. Copies of tax returns, pay stubs, and/or other information verifying income are required prior to approval of a discount. If defined documentation is unavailable, I will complete and sign the IRS 4506-T form to support this income statement.

Household Members		
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Income Documentation (list and attach):		
Income Documentation (list and attach):		
Income Documentation (list and attach):		
I understand that providing false information may result in legal action, and attest that all of the information that I have provided is true and correct to the best of my knowledge.		
Signed (Patient or Parent/Guardian):		Date:
If Guardian, Relationship to Patient:		
Witness:		Date:

Health Center use only		
Reviewer Notes:		
Date of Evaluation:	Income:	Discount Percentage:
Reviewer Signature:		Date: