Date Received: _____

Staff Initials: _____

North Florida Medical Centers, Inc.

APPLICATION FOR SLIDING FEE

DUE BY: _____

Patient Name: _____ _____
(Last) (First) (Middle) (Acct #)

Guarantor Name: _____ _____
(Last) (First) (Middle) (Acct #)

Guarantor Mailing Address: _____
(Street or Box #) (City) (State) (Zip) (County)

Guarantor Married Status: _____Single _____Married _____ Divorced _____Separated _____ Widowed

Guarantor Birth date: ____ / ____ / _____ Age: _____ Sex: ____F ____M
(month) (day) (year)

Guarantor Social Security # _____ Phone (Home) _____

Is Guarantor Employed? YES ____ NO _____ Occupation: _____

Employer's Name: _____ Phone: _____

Address: _____

Do you have any of the following? 1. Insurance _____ 2. Medicare _____ 3. Medicaid _____
(Yes/No) (Yes/No) (Yes/No)

FAMILY UNIT

(Notate beside names which type of coverage(s) apply)

Name	Type of Coverage	Relationship to Patient	Date of Birth	Sex

(Please list any additional members on the back of the form)

INCOME (All Sources Must be Included)

	Hours Per Week	Per Hour Rate	Weekly Rate	Monthly Rate	Yearly Rate
Head of Household					
Spouse					
Other					
Other					

TOTAL FAMILY MEMBERS:_____ TOTAL ANNUAL INCOME: $_____SLIDE FEE RANK: _____

By signing my name to this form, I am certifying the information given is true, accurate and complete to the best of my knowledge. I understand if I provide false information, I am liable for prosecution under State and/or Federal law. I give consent to NFMC to verify the information on this application. I understand this application must be renewed in 12 months from application date, unless indicated otherwise by Center Manager.

_____ ☐ **DECLINED** _____ / _____ / ____
Patient/Guardian Signature *Application Date*

_____ _____ / _____ / ____
Interviewer *Assessment Date*

Slide Fee Application Requirements

An application for slide fee, or discounted fee for services, is offered to all patients and must be renewed at least annually. The discount is based on gross family income and family size in accordance with Federal Guidelines set forth in the Federal Register. Income information is required by the federal government because we operate on a federal grant. The application must be completed, signed and returned with the following types of proper income verification in the **next ten (10) days.**

Copy of a completed and signed IRS Form 1040 (page 1 and 2) for the prior year,

Or any **two (2)** for the following:

1. IRS Form W-2 Wage & Tax Statement for the prior year;
2. Check stubs for two (2) recent pay periods from the employer(s) and rate of pay to insure consistency per pay period for each employed family member;
3. Complete Active Bank Statement - recent month with all pages without strike throughs;
4. Most recent Statement of Income Determination from public assistance program;
5. Verification of all current employment(s);
6. Most recent Statement of benefits, for example pension or annuity; and
7. Most recent Social Security Administration benefits statement.

The slide fee application must be completed with proper proof of income or you will be charged full price for your visit.

Slide Fee Single Fee Schedule Due at the time of the Appointment

Level A = $10.00
Level B = $15.00
Level C = $20.00
Level D = $30.00

Depending on your approved eligibility for slide fee discounts, the level's nominal fee is expected before each office visit.

_____

Patients Signature and Date acknowledging Patient understands the Slide Fee Program requirements.

NFMC
North Florida Medical Centers, Inc.

Attestation of the Lack of Income Documentation

Note: This form is only completed when a patient is unable to produce a second document to verify his/her income.

I, _____ am unable to provide a second document stating my
Patient/Guarantor Name
income. I am requesting a waiver to the requirement of a second income document to be included with my Slide Fee application, by signing this attestation.

(Check all types of documents, the patient/guarantor **does not possess**.)

- ☐ IRS Form 1040 for the prior year;
- ☐ IRS Form W-2 Wage & Tax Statement for the prior year;
- ☐ Check stubs for two (2) recent pay periods from the employer(s) and rate of pay to insure consistency per pay period for each employed family member;
- ☐ Bank Statement for the most recent month;
- ☐ Statement of Income Determination from public assistance program;
- ☐ Verification of employment;
- ☐ Statement of benefits, for example pension or annuity; or
- ☐ Social Security Administration benefits statement.

I declare that all statements made in this attestation statement are true and complete. I hereby authorize North Florida Medical Centers, Inc. (NFMC) to verify the information in this statement and obtain credit report on me. If I have given any false information NFMC is entitled to reject this Slide Fee application.

Patient/Guarantor Signature Patient Date of Birth Today's Date