Sliding Fee Scale Application Form

Patient Name: _____ New Patient: Yes / No Date of Application: _____

Patient Date of Birth: _____ Patient Age: ____ Patient SSN (Optional): _____

Spouse's Name (if married): _____ Spouse's SSN (Optional): _____

If patient is a child and/or disabled:

Parent/Guardian #1 Name: _____ Parent/Guardian #1 SSN (Optional): _____

Parent/Guardian #2 Name: _____ Parent/Guardian #2 SSN (Optional): _____
(If applicable)

List all who reside in your home that you are legally & financially responsible for:

	Name	**Relationship**	**Date of Birth**	**Age**
1				
2				
3				
4				
5				
6				

It is the policy of Compass Health to provide health care services at a cost that is affordable to its patients. The annualized incomes of the patients' households must be calculated and documented in order to provide health care services at an appropriate fee, based on Compass Health's Sliding Fee Scale / Nominal fee and as mandated by rules governing Federally Qualified Health Centers and Certified Community Behavioral Health Centers. This information may also assist Compass Health to help patients with other programs that offer financial assistance. If you are the parent or guardian of a minor or a legal guardian of an adult, please provide your financial information. If married, please provide both incomes.

COMPASS HEALTH STAFF: **Document sliding fee program eligibility by use of the Sliding Fee Eligibility Calculator Excel spreadsheet. This application, the Eligibility Calculator, and copies of income documentation used for screening must be scanned into the patient's file.**

I attest that the income information I have provided to Compass Health is true and accurate to the best of my knowledge. I understand that if I have been untruthful about my current income, I will become 100% liable for my Compass Health charges and I will not be eligible for the sliding fee program during future visits. I further understand that my eligibility for the sliding fee scale program will be re-determined at least annually and that I must report any change in my income and/or household size to Compass Health.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Compass Health Witness Date

12/29/2010
Revised 1/10/19 (AB)