Sliding Fee Application

It is the policy of AR Health to provide quality medical care to all people in need of care, regardless of income and/or the inability to pay. Please complete the following information so that AR Health will be able to determine your eligibility for discounted services. You will be reassessed for the sliding scale every six months, and you will be required to provide updated proof of income.

Patient's Name: _____ Affirmed Name: _____

Date of Birth: _____ Last four digits of Social Security Number: _____

Do you have commercial health insurance, Medicare, and/or Medicaid?

☐ Yes ☐ No ☐ Not Sure

HOUSEHOLD

A "household" includes legal children, a civil union partner, married spouse, and legal dependents. Please list the name of individuals in your household and their relation to you. Please use the back of this form for additional space.

Names of individuals living in the household (including yourself)	Relationship to you
TOTAL number of people in household:	

ANNUAL HOUSEHOLD INCOME

Source of Income	Self	Partner	Other	Total
Gross wages, salaries, tips, etc.				
Social Security (SSI or SSDI)				
Unemployment Benefits				
Investment Income				
Other				
TOTAL INCOME				

PLEASE READ AND SIGN

I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charged the full fee of my visit if I do not bring in income documentation by my third visit or within 60 days of my first visit, whichever comes first. I understand that I am required to notify AR Health if my income level changes or if I become insured.

If there are changes, I will be re-assessed for the sliding fee scale.

Print Name: _____

Patient Signature: _____ Date: _____

Guardian Signature (if applicable): _____

FOR INTERNAL USE ONLY

☐ $0 RW 0-100%

☐ $5 Non-RW 0-100%

☐ $10 101-125%

☐ $15 126-150%

☐ $20 151-175%

☐ $25 176-200%

☐ Full Fee (not eligible) greater than 200%

Reviewed By	
Effective Date	
Termination Date	

Date: _____

Date: _____