For Office Use Only:
Supervisor Signature: _____ Date: _____

Verified With: _____ Test Name: _____

Discounted/ Sliding Fee Application

Why do we need to know your household income?

- Some of LCHC funding comes from grant money. For most of these grants, income information from our patients is necessary to prove financial need in the communities we serve.
- These grants allow us to provide a much higher level and greater availability of care than we could otherwise afford.
- In order to obtain these grants, and to keep them, we need to provide demographic information, including financial resources of patients, to prove that we are serving the people the grant money has been set aside for.

I UNDERSTAND THAT:

1	The financial information I provide must be renewed each year unless there is a change in my current financial status prior to the renewal, in which case I must notify LCHC at my next visit and provide proof of the change.	_____ *Initials*
2	I must provide proof of my residence and will notify LCHC promptly of any address change.	_____ *Initials*
3	Proof of income is required at the time of visit, failure to provide acceptable documentation will result in being charged full price without any discount.	_____ *Initials*
4	First time patients will be allowed 30 days in which to submit required proofs of residence or income. **Failure to do so will result in being responsible for the full amount of charges without any discount.** I understand that I will be required to pay the sliding fee discount prices at the time services are rendered.	_____ *Initials*

Proof of Income (Employed)
- Current 1040 or other tax return
- W2
- 2 recent pay stubs
- Written & Signed document from the employer

Proof of Income (Unemployed)
- Public Assistance Check stub/copy
- Social Security check stub
- Letter from non-profit (e.g. church)
- Certification letter from DHS
- Notarized letter of person providing patients support

Proof of Address
- Utility bill in patients name
- Drivers License
- Any recently received mailing in patients name
- Notarized letter of person whom has knowledge of residence

Please list ALL household members:

Name	Date of Birth	Social Security #	Relationship to Patient	Income (for office use only)

****Patients applying for the sliding fee program are OBLIGATED to contact Lawton Community Health Center if the INCOME and/or HOUSEHOLD STATUS changes, or if they become eligible for INSURANCE.****

_____ _____ _____

Printed Name Signature Date

For Office Use Only:

Total # of members in household: _____ Total household YEARLY income: _____

Total household WEEKLY income: _____ SLIDING FEE CATEGORY: _____

Total household BI-WEEKLY income: _____

Total MONTHLY income: _____ Date:_____