BAY COMMUNITY HEALTH
SLIDING FEE DISCOUNT APPLICATION

PATIENT INFORMATION

Name: _____ Application Date: _____

Physical (living) Address: _____ Mailing Address: _____

_____ (if different) _____

Date of Birth: _____ Marital Status: Married Widowed

Home Number: _____ (circle one) Single Other:_____

Cell Number: _____

Work Number: _____

HOUSEHOLD SIZE

List below all members included in your household that can be claimed as a dependent on your tax return.

Name	Date of Birth	Relationship to Applicant	Age	Bay Community Health Patient?		Employed?	
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO

INCOME

As a part of this application, you will be required to provide proof of income. Please see the questions below to determine what documentation is required for your situation.

Are you employed? If so please specify: Full Time Part Time Self Employed Unemployed

List below sources of income other than employment wages:
Examples of other income include but are not limited to: Disability, Social Security, Stocks, Pensions/Retirement, etc.

_____ _____ _____

_____ _____ _____

What is the most recent year you have filed your federal tax return? _____

If you have filed in the past two years, please provide the most recently filed tax return and any following year W-2's (if applicable).

If you have not filed in the past two years, do you receive Social Security or Disability Income? _____

Please provide the most recent annual letter of benefits that specifies monthly income received.
NOTE: This letter of benefits is usually sent out in January of each year.

If neither of the above situations applies to you, please see the accounting office for more options on documenation required completion and processing of your application.

I certify that all of the above information is true and complete to the best of my knowledge with the understanding that any false or incomplete statement of family size and/or financial information may result in loss of eligibility for all household members listed. Explanation was provided to me by a Bay Community Health staff member regarding the sliding fee procedure and I fully understand my financial obligation of medical and/or behavioral health services until verification is provided for each household member listed.
Verification for each source of income is required to qualify.

_____
Applicant's Signature

BAY COMMUNITY HEALTH
SELF DECLARATION STATEMENT

I, _____ declare that I currently earn/receive $_____ per week/month/year.

(please circle)

Please list any additional statements regarding the status of your current situation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that all of the above information is true and complete to the best of my knowledge with the understanding that any false or incomplete statement may result in loss of eligibility.

_____ _____

Applicant Signature Date

BAY COMMUNITY HEALTH

IN KIND STATEMENT

(FOR APPLICANTS WITH NO INCOME)

Date _____

This is to certify that _____
(Person providing assistance)

Have been providing _____
(Applicant's name)

With free room and board since _____ and will continue to do so.

TO MY KNOWLEDGE THE APPLICANT HAS NO INSURANCE, NO INCOME OF ANY MEANS, AND IS NOT EMPLOYED.

MUST BE FILLED OUT BY PERSON "PROVIDING ASSISTANCE"

Name of Person Providing Assistance _____

Relationship to Applicant _____

Address of Person Providing Assistance _____

_____

Telephone Numbers of Person Providing Assistance _____

Signature of Person Providing Assistance _____

APPLICANT MUST RETURN WITHIN TWO WEEKS OF RECEIVING OR SLIDING FEE SCALE WILL BE CANCELLED.