RIVER HILLS COMMUNITY HEALTH CENTER
SLIDING FEE APPLICATION

The sliding Fee Scale is a method for providing reduced fees, based on a household's size and income. In order to be eligible for this program, the following application must be completed and submitted to the receptionist, along with **TWO most current pay stubs for all persons in the household or last year's income tax return as well as any other proof for the other Sources listed below.**

Head of Household: Last_____ First _____ Phone _____

Mailing Address: _____ City _____ State _____ Zip _____

NEW PROOF OF INCOME REQUIRED MARCH 1ST OF EVERY YEAR

SOURCES OF INCOME: All members living in the household. "Household" is considered all persons living with you at the same address. If living situation is temporary, please advise River Hills Staff of your situation.

Source	Amount	Weekly	BI-Wkly	Monthly	Annually
Salaries and Wages (self)	_____	[ ]	[ ]	[ ]	[ ]
Salaries and Wages (spouse)	_____	[ ]	[ ]	[ ]	[ ]
Salaries and Wages (other)	_____	[ ]	[ ]	[ ]	[ ]
Workmen's Comp (SIIS)	_____	[ ]	[ ]	[ ]	[ ]
Social Security (Self/Spouse)	_____	[ ]	[ ]	[ ]	[ ]
Social Security (Children)	_____	[ ]	[ ]	[ ]	[ ]
SSI (Supplemental Security)	_____	[ ]	[ ]	[ ]	[ ]
Child Support / Alimony	_____	[ ]	[ ]	[ ]	[ ]
Military / Veterans Benefits	_____	[ ]	[ ]	[ ]	[ ]
Unemployment Benefits	_____	[ ]	[ ]	[ ]	[ ]
Other Family Members	_____	[ ]	[ ]	[ ]	[ ]

HOUSEHOLD SIZE: List all household members by NAME, BIRTH ;include yourself.

NAME	BIRTHDATE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE READ THE FOLLOWING CAREFULLY!!

I, the undersigned, have completed this application for Sliding Fee eligibility and confirm that this information is true and correct, to the best of my knowledge. I further understand that any change in financial status or the number of people in my household must be reported immediately to River Hills Community Health Center and a new application must be completed. I understand that, upon request there will be an annual review of my application with the possibility of discount percentage changes. I understand any falsifications or the failure to report any changes may result in my being made ineligible for the Sliding Fee adjustments made available by River Hills Community Health Center. **I understand that I must provide the needed proof of income within 30 days of this application in order for any discount to be applied.**

Applicant's Signature _____ Date _____

Witnessed by (RHCHC representative) _____

_____ Approved _____ % of discount approved _____ Expiration Date

_____ Pending Reason_____

Certified by:_____ Date _____

Updated 6/1/2023