Our patients mean the world to us.
Family HealthCare Center

Sliding Fee Scale Application

NOTE: To comply with federal regulations and give you a discount on our medical services, it is necessary to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Your yearly income tax return, a copy of your last month's paycheck stubs, copies of your social security benefit letter, or other income verifications will be sufficient proof.

First Name:	**Middle:**	**Last:**	**Other names:**	
Home Address:		**City:**	**State:**	**Zip:**
Phone #:		**Social Security #:**		
Date of Birth:		**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **In a Relationship**		
Do you consider yourself homeless?	**Are you a MN resident?**		**Have you applied for medical assistance?**	

Household Members	**NAME**	**Date of Birth** Month/Day/Year	**Social Security Number**	**Health Insurance**	**Relationship**	**Patient at FHC?**

Income	**Monthly/Annual Income**	**For YOU**	**For SPOUSE**	**For Children**	**For Other**	**Subtotal**
	Gross wages, salaries, and tips					
	Social security & pensions					
	Annuity & veteran benefits					
	Child support & alimony					
	Self employment & Other					
					TOTAL	

Verification of income is mandatory. By signing below, I agree that Family Healthcare Center (FHC) may contact each employer of all persons working in the above mentioned household and/or may contact various agencies to verify any source of income. Within 30 days, I will provide FHC with a copy of all requested information, as listed, for all persons in the above mentioned household.

I will be asked to reapply for the SFS at least once a year so FHC can maintain an updated SFS application on file. I am obligated to inform FHC of any change in household size, income, and/or insurance. I am also obligated to provide FHC with any income information that is requested. Patients without complete income information may be given temporary SFS only once every 12 months. Applications lacking required information will be denied without notice after 30 days.

*If you consider yourself homeless you will be required to apply for Homeless Health Services. *If you are a MN resident you are required to provide FHC with an acceptance or a denial from MN Medicaid within 1 month of applying.

Temporary Application	
PR Initials	
Patient ID#	
MA Verified	
Completed Application	
PR Initials	
GMI	
Effective Date	
Expiration Date	

I verify that all information provided on this form is true and correct. Fraudulent self-reporting on any portion of this application may jeopardize your status at FHC and/or be punishable by law.

SIGNATURE: _____ **DATE:** _____

NAME PRINTED: _____

INTERPRETER NAME: _____