COMMUNITY HEALTH SERVICE INC

SLIDING FEE DISCOUNT APPLICATION FORM

Patient ID: _____

HOUSEHOLD INFORMATION

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I acknowledge that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee discount program. I further agree to inform Community Health Service Inc. if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Community Health Service Inc. I hereby acknowledge that I read the foregoing disclosure and understand it.

I consent to the release of any and all of my financial records including but not limited to the following: sliding fee scale application and supporting documentation, patient information, insurance information, and any other types of information contained within my electronic health and/or dental records that may be deemed necessary for review by any auditor, for participating in any assistance programs including but not limited to sliding fee scale, grant-funded programs and/or pharmacy assistance programs for which I may be eligible.

Total of household income with proof $_____

Total # of household members: ____

Calculated sliding fee: ___%

Date: _____

Name (Print): _____

Signature: _____

Witnessed by CHSI staff_____