



SELF DECLARATION FOR SLIDING FEE ELIGIBILITY

ANTHONY L. JORDAN HEALTH CENTER

We appreciate the opportunity to provide you with health services. You will be asked to fill out our patient information form and medical history form. All patient records are strictly confidential and cannot be released without your permission.

All charges and fees are based on a sliding fee scale. Services rendered are expected to be paid for the date of service. The sliding fee scale is based on total household size and income. In order to qualify for the sliding fee scale, you must provide one of the following sources of information:

TO VERIFY INCOME

- Paycheck stub (latest four, 4)
- Copy of actual check (4)
- Income Tax statement (latest year)
- Letter(s) from agency receiving payment from Social Security, Social Services VA
- Employer letter

TO VERIFY HOUSEHOLD SIZE

- Unemployment papers
- Birth Certificates of dependent children
- Copy of income taxes which list the dependents
- Lease agreement listing persons in
- Other legal/verifiable documents

A minimum charge for services rendered is \$10.00 for the office visit and \$10.00 for any outside lab work necessary. There is also a minimum \$10.00 for other procedures. Sources of acceptable payments are:

1. Cash
2. Check
3. Medicare
4. Medicaid
5. Private Insurance

Self-Declaration of required information:

My current total household income is \$ _____.

My current total number of household members is _____.

I have read the above information and understand the qualifications and documentation necessary to apply for the sliding fee scale.

I further understand that if I do not provide the necessary information with 30 days, I will be required to pay 100% of charges for all future services received by the Health Center.

Signature: _____

Date: _____

Staff Signature: _____

Date: _____

SLIDING FEE ELIGIBILITY FORM

**Anthony L. Jordan Health Center
82 Holland Street
Rochester, NY 14605**

Name:
Address:
City, State:
Zip Code:
Telephone:
Social Security #:
Date of Birth:
Chart Number:

It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file in our center in strict confidence. You must verify your income at least every six months. Your yearly income tax return with a copy of your W-2 form, payroll check stubs covering the past six months, or copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income will be used to calculate the level of your payment.

Today's Date: _____ Number of people living in your home: _____

What is your marital status? _____ Married _____ Widow(er) _____ Single _____ Divorced _____ Separated

Give names, addresses and or phone numbers of the employers for you, your significant other, children, other household members.

Name:	Name:
Address:	Address:
City, State:	City, State:
Phone Number	Phone Number

Place of Employment?
Address

You	Your Spouse	Your Children	Other Person

Contact Person

Do you receive any income from any of the following sources, and if so, how much?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Rental Income					
Interest Income					
Child Support, Alimony					
Other (Specify)					

Do you have any type of insurance? _____ Yes, list below _____ No
Insurance Carrier _____ Insurance Number _____

Amount of Family Income?

You	Your Spouse	Your Children	Other Person	Total Family Income

SECTION II-3

I declare the above information is true and have given the Anthony L. Jordan Health Center permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am require to notify the receptionist on my next visit to the center.

Patient Signature _____
Employee Signature _____

Date: _____
Date: _____

ANTHONY L. JORDAN HEALTH CENTER

List Dependent Children

	Name	DOB	Social Security #	OTHER PROOF DOCUMENT
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

List Other Household Members

	Name	Relationship	DOB	Social Security #	OTHER PROOF
1.					
2.					
3.					
4.					
5.					