APPLICATION FOR DISCOUNT PROGRAMS

Billing Office Approval
☐ Self-Pay
☐ Sliding Fee ☐-B ☐-C ☐-D ☐-E ☐-F
☐ Homeless Program
Patient #___________ Guarantor #____________
Initials ___________

HEAD OF HOUSEHOLD

Name (Last, Legal First, M.I.) Date of Birth (mm/dd/yyyy)

Address City State Zip Phone

SSN Email Address

List Names in Household (Last Name, First Name)	Date of Birth	Relationship	Employer	Health Insurance	Patient at Clinic
		Self			☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No

Do you have a permanent home (house, apartment, etc.)? ☐ Yes ☐ No

If no, where did you spend last night? ☐ Shelter ☐ Street ☐ Friends/Relatives ☐ Other: _______________

—THE FOLLOWING ITEMS WILL BE ACCEPTED AS FORMS OF INCOME VERIFICATION—

- Income tax form for previous year.
- Statement from social security/disability.
- One month's worth of pay stubs.
- Notice of action from food stamps, unemployment.
- Other copies pertaining to child support, TANF, etc.
- Notes on letterhead from an organization assisting a patient with their financial status.
- If unemployed within the last month, documentation of income earned prior to loss of employment.
- Full-time student and not working; student schedule showing classes for the current semester.
- If you are unable to prove income, contact the Billing Office for more information.

—PLEASE READ CAREFULLY BEFORE SIGNING—

The Sliding Fee Scale Program is based on household size and gross income. Verification of income is mandatory. By signing below, I agree that Falls Community Health 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.

I will be asked to reapply for the Sliding Fee Scale Program at least once a year. I am obligated to inform Falls Community Health of any change in household, income, and/or insurance. Applications lacking required information will be denied without notice after 30 days.

I verify that all information provided on this form is true and correct.

Signature **Date**

Please return completed form and income verification materials (by mail or in person) to:

Attention: Billing Office
Falls Community Health
521 North Main Avenue, Suite 100
Sioux Falls, SD 57104