Sliding Fee Application

Staff Use ONLY	
Source of Income: ☐ Pay stub ☐ W2/1040 ☐ Income verification letter ☐ Self-declaration letter ☐ Other_____	
Income Obtained ☐ Yes Both ☐ No	Income 1_____ Income 2_____ Total Average _____

Patient Name:	**DOB:**		**Date:**	
Household members	Date of Birth	Frequency	Gross Income (Before Taxes)	CRCHC Patient (Yes/No)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

☐ Please check box if you would like to add sliding scale to all CRCHC household members listed above.

% Approved (Staff use only)	
☐ A ☐ B ☐ C ☐ D ☐ E ☐ F (Full Charge)	☐ I provided income today ☐ I will bring income within 10 days ☐ I self-declare no income (comments) _____ ☐ I have been given the opportunity to apply for the CRCHC Sliding Fee Scale Program, and I decline the opportunity to apply for the CRCHC Sliding Fee Discount program

I understand the information I provide is subject to verification by CRCHC. I agree the above information is true and correct to the best of my knowledge. I understand that providing false information can result in me being denied ability to apply for the discount program, furthermore, I agree to adhere to all terms and conditions of the Sliding Fee Discount Fee Discount Program. I will report any changes of the above information to CRCHC. I understand that if I am applying for financial assistance and do not have any source of income or do not have proof of income with me today, CRCHC will discount my services for today based on estimated income. **However, I will be totally responsible for any subsequent visits at CRCHC, if I do not bring proof of income within 10 days.**

I agree to PAY the assigned sliding scale fee at the time of service.

Patient (Legal Guardian Signature): _____ Date: _____

CRCHC Staff Signature: _____ Date: _____