Fair Hill Community Physicians

Sliding Fee Discount Program Eligibility Form

	Household Income *(enter 1 only)*	Household Size
Household/Family is all persons physically residing in the same home, who are the legal responsibility of the guarantor.	**Bi-weekly: _____** **Monthly: _____** **Annual: _____**	

Documentation must be provided by the patient or guarantor to determine eligibility for the Sliding Fee Scale

1. I understand that the information I provide on this form is subject to verification by Fair Hill Community Physicians
2. I understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.
3. I hereby attest that this information is true, accurate, and complete to the best of my knowledge, and that I understand that any falsification, omission, or concealment of material fact may subject me to disqualification from the Sliding Fee Discount Program
4. I understand that it is my responsibility to notify Fair Hill Community Physicians of any changes in income or insurance and that my income information is only valid for 1 year.
5. I understand that income documentation must be provided within 30 days of my first visit after January 1st, 2024. If adequate documentation is not provided, I understand I will be removed from the program, and charged the full fee for the visit.

ACCEPTABLE INCOME DOCUMENTATION

Pay stubs
1040 tax forms
W2 forms
Social Security proof of income letter
Pension Distribution Statement
Unemployment Benefits letter
Worker's Compensation letter
1099 tax forms
Signed letter from employer (must contain a contact person, phone number, and address)
All other proof of income documents not listed above will be reviewed by a Fair Hill director
All proof of income documents are waived for homeless individuals

☐ I decline to provide household income and household size.

_____	_____	_____
Patient/Guardian Signature	Printed Name	Date
_____	_____	_____
Fair Hill Staff Signature	Printed Name	Date
_____	_____	_____
Fair Hill Staff Signature	Printed Name	Date

Fair Hill Community Physicians

Formulario de Elegibilidad para el programa de Descuento Escala Mínima

Hogar / Familia son todas las personas que residen fisicamente en el mismo hogar y que son responsabilidad legal del garante.	Ingreso	Hogar

El paciente ó el garante debe proporcionar la documentación para determinar la elegibilidad para la Escala Mínima

1. Entiendo que la información que proporcione en este formulario está sujeta a verificación por parte de Fair Hill Community Physicians.
2. Entiendo y acepto cumplir con todos los términos y condiciones del Programa de descuento Escala Mínima.
3. Doy fe de que esta información es verdadera, precisa y completa a mi leal entendimiento y comprendo que cualquier falsificación, omisión u ocultación de un hecho puede someterme a la descalificación del Programa de Descuento Escala Mínima.
4. Entiendo que es mi responsabilidad notificar a Fair Hill Community Physicians de cualquier cambio en los ingresos o el seguro.
5. Entiendo que la documentación de ingresos debe proporcionarse dentro de los 30 días posteriores a la inscripción en el programa de tarifas variables. Si no se proporciona la documentación adecuada, entiendo que seré eliminado del programa y se me cobrará la tarifa completa por la visita.

Documentación de Ingresos Aceptables

TALONES DE PAGO
1099's
CARTA DE "SNAP"
W2 0 DECLARACION DE IMPUESTOS FEDERALES
CARTA DE LA COMPANIA CON LOS INGRESOS AN UAL (CARTA DEBE TENER NOMBRE DE CONTACTO Y NUMERO DE TELEFONO)
CARTA OFFICIAL/DOCUMENTOS DEL SEGURO SOCIAL, CORTE, MAN UTE NCI ON DE MENO RES, ETC. FORMA DE VERIFICACION DE INGRESO COMPLETADA Y FIRMADA POR EL EMPLEADOR

☐ Actualmente, no deseo inscribirme en el Programa de Escala Mínima

_____	_____	_____
Firma del paciente / garante	Nombre impreso	Fecha
_____	_____	_____
Fair Hill Staff Signature	Printed Name	Date
_____	_____	_____
Fair Hill Staff Signature	Printed Name	Date