KONZA PRAIRIE Community Health & Dental Center

Sliding Fee Scale Application

Clinic Site: _____

Because we are a Community Health Center, we have the opportunity to offer a discount on your services based on your annual income. If you feel this may be a benefit to you and your family, you will need to complete the Sliding Fee Scale program application and provide verification of income.

Head of Household Information:

Name: (First, middle initial, Last):	Social Security Number:	Date of birth:	County:
Address	City/State/Zip:	Home Phone:	Work Phone:
# of people being supported in the home:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		

Income Information: Please complete for all adult household members who are employed: **PROOF OF INCOME (INCOME TAX RETURN AND/OR LAST THREE PAYSTUBS) MUST BE PROVIDED TO KPCHC.** Otherwise, services will be rendered at customary price.

If your income is $0, how are you meeting your food, clothing, shelter and transportation needs?

Employed Person	Company Name	Income (Before Taxes)	Paid how often? (Check One)
		$	☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
		$	☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
Other sources of income:	Alimony $	TANF $	Pension/Retirement $
Child Support $	Disability $	S.S.I. $	Social Security $
Unemployment $	Other $	Other $	Other $

Household Information: List ALL individuals in household, including the head of household.

Name	Date of Birth	Relationship	Age	Income	Employed
1.					**Yes/No**
2.					**Yes/No**
3.					**Yes/No**
4.					**Yes/No**
5.					**Yes/No**
6.					**Yes/No**

Medical Application: ☐ Dental Application: ☐

By signing below, I agree that the KPCHC staff may contact each employer listed and or other agencies to confirm my income. I will provide KPCHC with proof of income for the purpose of calculating my discount. I will be asked to reapply for the program on an annual basis. I agree to inform KPCHC if there are changes to my income, household size or insurance coverage. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of services. I hereby certify that the information I provide is correct.

Applicant Signature: _____ Date: _____

Guardian or Power of Attorney Signature: _____ Date: _____

Please make sure that you include your proof of income with this application

Account #	
Effect Date	
Total Income	
Discount %	

Revised 9/19/2011