NorthShore HEALTH CENTERS

Sliding Scale Application

It is the policy of NorthShore Health Centers to provide quality medical care regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. The discount will apply to certain services received at any of our clinics, but not services or equipment that are provided by outside entities. Please complete the following information to determine if you or members of your family are eligible for a discount.

PATIENT INFORMATION		**Today's Date: ___ / ___ / _____**
Last Name	**First**	**M.I.**
Date of Birth ___ / ___ / _____	**Social Security No. - -**	

HOUSEHOLD SIZE - List all members of the household who are pooling financial resources. This is to include spouse/partner, all children, and all dependents living in the home.		
First and Last Name	**Date of Birth**	**Relationship to Patient**

ANNUAL HOUSEHOLD INCOME					
Source of Income	You	Spouse/Partner	Children	Other	Subtotal
Wages, Salary, Tips					
Social Security Benefits					
Unemployment Compensation					
Self-Employment Income					
Alimony					
Retirement and Pension Income					
Investment and Rental Income					
Other					
Total Annual Income					

Please return **copies** of the following documents to support your Sliding Fee Application

- Most recently filed federal tax return
- If tax return is not available, please provide: *Paycheck stubs from current or most recent employer, one month's worth*
- If unemployed, please provide all sources of other income such as but not limited to: *Unemployment Award Letter, Social Security/Disability Benefit Letter, etc.*
- Other forms of income that may apply to you, lease provide proof of: *Alimony letter from court and/or check stub, Retirement and Pension Income, Investment and Rental Income*

Please Read and Sign

I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charged the **full fee of my visit** if I do not bring in documentation of income **within 30 days of my first visit**. I understand that I am required to notify NorthShore Health Centers if my income level changes or if I become insured. If there are changes, I will be re-assessed for the sliding scale.

Print Name: _____

Patient Signature: _____ Date: _____

Declination Statement (for Patient's who do not want to comply with Sliding Scale Requirements)

Because you do not wish to apply or comply with the requirements to apply for our sliding scale discount, you are choosing to be a self pay patient. This means that you will pay **$65** up front at the time of service and you will be responsible for any and all balances due after the provider's charges for your visit are entered. You will also be responsible for any other charges for today's visit. Any discount for office charges are not applicable and you will not be allowed to receive a discount for these charges in the event that a future sliding application is completed.

Patient Signature: _____ Date: _____

Self-Declaration of Income

Please complete the information below only ***if you have no other way to document your income***. All of the boxes below must be checked and all of the questions answered. Failure to complete this information will result in denial of you application for a sliding scale discount.

☐ I get paid in cash.
☐ I do not get pay checks.
☐ I do not get pay stubs.
☐ I cannot get a letter from my employer. Explain why: _____
_____

My cash income is $ _____ How often? ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Current Employer: _____ ☐ Other: _____

Patient Certification Statement

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the NorthShore Health Centers Sliding Fee Discount Schedule. I understand that NorthShore Health Centers may verify information on this form. The provision of false information by an applicant may result in dismissal from the sliding fee discount program.

Patient Signature: _____ Date: _____

Office Use Only

Application Received Date: _____ By: _____

Eligibility Determination: ☐ Approved ☐ Denied Approval Date: _____

If Approved, eligible for Discount Category: ☐ Slide A ☐ Slide B ☐ Slide C ☐ Slide D

If Denied, reason for Denial: _____
_____

Verification Checklist	Yes	No
Identification Verification Source: Driver's License, State Issued ID, Passport / Visa, School Issued ID, or Other		
Income Verification Source: Recent Pay Statements, Prior Year Tax Return, Letter from Employer, or Other		

Employee Signature: _____ Date: _____