NEPA Community HEALTH CARE

APPLICATION FOR SLIDING FEE SCALE

Date of Application: _____

Patient's Name: _____ Date of Birth: _____

Address: _____

_____

Parent/Guardian if Different from Patient: _____

Telephone Number: (____) _____Cell Phone: (____) _____

Are You Married? Yes _____ No_____ Widow(er)_____ Separated _____

Are you currently a patient in more than one of our centers? Yes_____ No_____

If so, please specify which centers:

Montrose: _____ Hallstead: _____ Greenfield: _____ Elk Lake School: _____

Occupation: _____

Employer: _____

Do you currently have any medical insurance? Yes_____ No_____

If yes, please complete the following information: (medical)

Name of Insurance: _____

Policy Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Do You currently have any dental insurance? Yes_____ No_____

If yes, please complete the following information: (dental)

Name of Insurance: _____

Policy Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Mail or Email Application & Documentation to:
NEPA Community Health Care
498 S Main Street, Suite D
Montrose, PA 18801
Email: sfsdapps@nepachc.org

For Office Use Only

Date Approved_____
Sliding Fee Level_____
Approved By_____

NEPA Community HEALTH CARE

APPLICATION FOR SLIDING FEE SCALE

HOUSEHOLD MEMBERS

****LIST ONLY YOURSELF & DEPENDENTS WHO ARE ON YOUR INCOME TAX RETURN**

****ALL OTHER MEMBERS IN HOUSEHOLD NEED TO APPLY SEPARATELY**

Name	Date of Birth

INCOME: (LIST ALL HOUSEHOLD INCOME FROM THE FOLLOWING SOURCES):

Do You File a Tax Return? Yes_____ No_____

If Yes, please provide a copy of your most recent income tax return. **If No**, or if you do not have a copy of your tax return, please provide current information below, along with **supporting documentation**.

Income Source	Amount (per week/month/year)
Wages	$
Social Security/Disability	$
Self-Employment/Unemployment	$
Public Assistance/Child Support/Alimony	$
Dividend/Interest Income/Pension	$
Other	$

Change of Circumstances: Since the date that you filed your last income tax return, has your income/financial circumstance changed drastically? Please detail the way it has changed.

_____

_____

_____

I affirm that the above information is true and correct to the best of my knowledge.

Signature:	Date
Relationship to Patient(s):	