COAL COUNTRY COMMUNITY HEALTH CENTER

1312 HWY 49 N, BEULAH, ND 58523

SLIDING FEE SCALE APPLICATION

- **SECTION A**

Responsible Party: ____
Last Name First Name M.I. Date of Birth

Billing Address: ____
City State ZIP Code

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________

Social Security #: ______________________ Place of Work: ______________________

- **SECTION B**

Please complete table for individuals in the household:
NOTE: (DO NOT list individuals that the responsible party is not LEGALLY responsible)

Last Name, First Name	Date of Birth	Does person have health coverage?	Insurance Carrier: Medicaid, Medicare, BCBS, CHIP, etc.	Policy/ID Numbers
		☐Yes ☐No		
		☐Yes ☐No		
		☐Yes ☐No		
		☐Yes ☐No		
		☐Yes ☐No		

- **SECTION C**

Please list income of all adult household members who are employed:

Person Employed	Company Name	Income Before Taxes	How Often? (Circle)
		$	Monthly / Yearly
		$	Monthly / Yearly

OTHER SOURCES OF INCOME – Please indicate if income is per week/month/year/etc.

Pension/Retirement $ /	Alimony $ /	TANF $ /
Disability Pay $ /	Child Support $ /	SSI $ /
Unemployment $ /	Other $ /	Social Security $ /

NOTE: Include income from all persons in household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, veterans' payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.

- **SECTION D**

Please read carefully before signing:

Proof of Income:

Proof of income is required. By signing below, I agree that Coal Country Community Health Center (CCCHC) staff may contact each employer of all people working in the home and/or may contact other agencies to confirm the income listed. Within 30 days, I will give CCCHC a copy of all information asked for, for all people in the home to see if I qualify for reduced fees.

NO INCOME APPLICANTS

Non-income applicants must complete the non-income verification form. (see page 3 of application) So that the CCCHC may have a current Billing Form on file, I will be asked to reapply for the program annually. I will update my application if the people living in my home change, our income changes, or our insurance changes. If I do not send in proof of information or provide correct information, I may not be eligible for reduced fees.

______________________________ ______________________

Signature Date

Permission for Insurance:

I give permission to my insurance company to directly pay CCCHC for services given to me by any medical or dental provider. I know that if my insurance does not cover all of the costs, I will have to pay the bill. I give permission to CCCHC to release all information needed to get the insurance payments.

The information I have given is correct. I ask that the payment of benefits be made on my behalf. A photocopy of this form is as valid as the original.

______________________________ ______________________

Signature Date

I understand that any labs done at Coal Country Community Health Center will qualify for the SFS. Any lab work that is sent to an outside lab will be my responsibility.

Patient/Guardian Signature ______________________________

Financial Counselor Signature ______________________________

Date Signed ____________________

For CCCHC Use Only

Income: $____________________ Monthly or Yearly Sliding Fee Scale Discount: ______

CCCHC Representative Signature: ______________________________ Date:____________

Non-Income Verification for Sliding Fee Scale

Name of Patient____Date___________

(Please Print)

Name of 3rd Party______________________________

(Please Print)

Phone Number of 3rd Party_________________________

Address of 3rd Party________________________________

____

____

(Please Print)

I, _________________________, certify to my best knowledge that

_________________________, a patient at CCCHC, has no income at this time.

Signature of 3rd Party____Date__________

*CCCHC requires proof of no income; we require a 3rd party signature verifying the applicant is unemployed. Please have a 3rd party sign above.