HI-DESERT
FAMILY HEALTH CLINICS
HI-DESERT MEMORIAL HEALTH CARE DISTRICT

APPLICATION FOR FEE DISCOUNT

Name *(all household family members/dependents)*	**Relation**	**Date of Birth**	**Income**	**Frequency**	**Source of Income**
	Self				

I understand that the information I provide on this form is subject to verification. I certify that the above information is true and correct to the best of my knowledge and that I understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.

Patient/Guardian Signature _____ Print Name _____ Date _____

DO NOT WRITE BELOW THIS LINE

	Acceptable Income Documentation [Enter (✓) if obtained and verified]	**Calculated Amount Associated with Documentation**
	Last 2 paycheck stubs (Must be dated within last 30 days. If the amounts vary, an average will be taken)	
	Current Federal Tax Return	
	Company letter stating earnings and hours (Letter must contain a contact person and phone number)	
	Official Letters/Documents from Social Security, Courts, EDD, etc.	
	Total Income Amount	

☐ Patient at or below FPL; nominal fee only
☐ Patient pays 25% of charges ☐ Patient pays 50% of charges ☐ Patient pays 75% of charges
☐ Patient above 200% of FPL; pays full charges

Effective Date _____ Expiration Date _____

Staff Signature _____

⇨ **Scan into patient's electronic record with all supporting documents**