CANYON Pediatrics

SLIDING FEE APPLICATION

The Sliding Fee Scale is a method for providing reduced fees, based on a household's size and income. In order to be eligible for this program, the following application must be completed, signed & dated, and submitted to the receptionist. Patients may have up to two weeks to submit proof of income (see listing on back side for acceptable forms of income)

Head of Household: Last_____________________________ First _______________________ Phone _______________
Mailing Address: __________________________________ City ___________________ State _________ Zip ________

Have you or any of your household members applied for Medicaid (Title XIX)? Yes ☐ No ☐

SOURCES OF INCOME: All members living in the household. "Household" is considered all persons living with you at the same address. If living situation is temporary, please advise staff of your situation.

Source	Amount ($)	Weekly	Bi-Weekly	Monthly	Annual
Salaries and Wages (self)		☐	☐	☐	☐
Salaries and Wages (spouse)		☐	☐	☐	☐
Salaries and Wages (other)		☐	☐	☐	☐
Workmen's Comp (SIIS)		☐	☐	☐	☐
Social Security (Self/Spouse)		☐	☐	☐	☐
Social Security (Children)		☐	☐	☐	☐
SSI (Supplemental Security)		☐	☐	☐	☐
Child Support / Alimony		☐	☐	☐	☐
Military / Veterans Benefits		☐	☐	☐	☐
Unemployment Benefits		☐	☐	☐	☐
Other Family Members		☐	☐	☐	☐

HOUSEHOLD SIZE: List all household members by NAME, DATE OF BIRTH, AND SOCIAL SECURITY NUMBER, include yourself:

Name	Date of Birth	Relationship	Social Security #

PLEASE READ THE FOLLOWING CAREFULLY

I declare that my household's financial status is as listed above. I understand the following:

- This program is funded solely by Canyon Pediatrics and is not connected to any federal or state agency
- This program may be discontinued at any time based on availability and ability to serve patients
- Giving false information regarding my household income is considered healthcare fraud
- Any change in my finances or the number of people in my household must be reported and a new application must be completed

Applicant's Signature ____ Date ________________________

Reviewed 4/1/19

Income Verification

You are required to provide proof of listed income in order to complete your application. The following are acceptable forms of income:

- Prior year W-2
- Two most recent pay stubs
- Letter from employer
- Form 4506-T (if W-2 not filed)
- Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business.
- Current bank statement showing direct deposit (SS, SSI, SSD, Fip, Child support)
- Printout from office issuing payments (SS, SSI, SSD, unemployment, VA, etc)
- Pension payments, Veteran's Benefits
- Court order for alimony or child support or printout for child support payments
- Employer statement for cash wages (must include employer name, address and phone number)
- Self-declaration of Income may only be used in special circumstances. Specific examples include participants who are homeless. Patients who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to Canyon Pediatrics CEO or his/her designee for review and final determination as to the sliding fee

Official Use Only:

Pt Number #: ______________________

Application Received/Entered: Date: __________________ By: ____________________

Calculated Income Total: $_________________________________ Household Size: ________________

Sliding Fee Scale Level Approved: _____________________________

Labs SFS Level Approved: _____________________________

Reviewed for past dates of service for adjustments: ☐ Yes ☐ N/A By: ________________

Patient Notified of SFS Application Status: ☐ At office/in person ☐ Reached patient by phone

☐ Attempted by phone/didn't reach patient Date: _______________

Reviewed 4/1/19