# Sliding Fee Application

**"This form must be witnessed and signed by an Acute Care Pediatrics staff member."**

Please note that this is only an application, and your eligibility will be determined by Acute Care Pediatrics' sliding fee discount policy. This is based on the household size and annual income. Please complete all portions and submit proof of income as necessary. ******ONLY ONE APPLICATION PER HOUSEHOLD (FAMILY)******

| **Patient Information** | | |
|---|---|---|
| Date: | Primary Office: Please circle one: Palatka - Palm Coast | |
| First Name: | Middle Name: | Last Name: |
| DOB: | Does the patient have any health insurance? YES ( ) NO ( ) | |

| **Parent/Guardian Information** | | | |
|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | DOB: |
| Home Address: | | | |
| City: | State: | | Zip Code: |
| Billing Address: | | | |
| City: | State: | | Zip Code: |
| Home Phone: | Cellphone: | | Work phone: |
| Marital Status: Married ( ) | Separated ( ) | Divorced ( ) | Single ( ) Widow ( ) |
| How many household members live in the house, including the patient? Total Number: | | | |

******PLEASE LIST ON THE FOLLOWING PAGE ANY SIBLING INFORMATION******

| **Total Household Monthly Income**<br>**NOTE:** Including salary, Social Security, Retirement Pension, Food Stamps, Child Support, and other sources of income. | |
|---|---|
| Guardian/Parent 1: $_____ / monthly | Guardian/Parent 2: $_____ / monthly |
| Overall Total Household Income: $_____ / monthly | |

**By signing below, I acknowledge the following:**
**To comply with federal regulations and to offer me a discount on my medical services, Acute Care Pediatrics must ask personal questions. My answers will be kept on file with strict confidentiality. I must reapply every six months to determine my continued eligibility. My household size and income will determine my eligibility for this benefit, and I may bring any of the following proof of income (household's current income tax return, a copy of W2 forms, last month's paystubs, approval letter/form with SSA/SSI annual income, or any other proof of income received in the household) as necessary. I affirm that the information provided on this application is true and correct to the best of my knowledge and beliefs. I agree that any misleading or falsified information, and/or admission may disqualify me from further consideration for the sliding fee program. I further agree to inform Acute Care Pediatrics of any significant change in my income. If acceptance of the sliding fee program is obtained under this application, I will comply with all the rules and regulations of Acute Care Pediatrics. I hereby acknowledge that I have read the foregoing disclosure and understand it.**

| **Signature:** | **Print Name:** | **Date:** |
|---|---|---|

| Acknowledgment of Receipt of Offer of Sliding Fee Application | | |
|---|---|---|
| **By signing below, I acknowledge that I was offered the opportunity to apply to Acute Care Pediatrics' sliding fee program. I understand that this is merely an offer and that I have the option to apply for the sliding fee program or decline the opportunity to do so.**<br>**Please check one:**<br>○ **I ACCEPT the opportunity to apply for the sliding fee program**<br>○ **I DECLINE the opportunity to apply for the sliding fee program** | | |
| **Signature:** | **Printed Name:** | **Date:** |
| **Patient Name:** | **DOB:** | |

| Sibling Name: | Sibling DOB: |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |
| **5.** | |
| **6.** | |
| **7.** | |
| **8.** | |
| **9.** | |
| **10.** | |

**NOTE: This section is for Acute Care Pediatrics staff only.**

| **OFFICE USE ONLY** | |
|---|---|
| Application Reviewed by: (Front Desk Employee): _____ | Date: _____ |
| Application Verified by: (Billing Dept. Employee): _____<br>○ **Approved**<br>○ **Denied / Reason: _____** | Date: _____<br><br>Date: _____ |