Charlotte Community Health Clinic, Inc.

ESTABLISHED PATIENT SLIDING FEE DISCOUNT PROGRAM APPLICATION

Charlotte Community Health Clinic is committed to providing quality health care to all members of the community regardless of their ability to pay.

All patients of Charlotte Community Health Clinic with household income at or below 200% of the Federal Poverty level and that provide required documentation will be eligible for medical, dental, and prescription discounts.

Two pieces of information are required in order to qualify: the amount of money earned in the household and the number of people who live in the household. To be eligible for the Sliding Fee Scale, you must provide accurate and acceptable proof of income as well as list all persons within the household.

PLEASE RETURN THE ATTACHED APPLICATION AND PROOF OF INCOME (see below list) TO CCHC PRIOR TO YOUR NEXT APPOINTMENT OR YOU WILL BE RESPONSIBLE FOR 100% OF ALL CHARGES AT THAT APPOINTMENT.

PLEASE PROVIDE COPIES – WILL NOT BE RETURNED (documents will be shredded for privacy after use)

Acceptable Proof of Income – Provide for each adult listed on application

- Most recent Federal Income Tax Return
- W-2 forms
- 30 days most recent pay stubs (more is better)
- Employer’s Letter on letterhead (must include contact name and phone number)
- Agency letter: A letter from the Social Security Administration, Veterans Administration or Social Service Agency indicating income level.
- Unemployment Verification: Paperwork from the Employment Securities Commission (ESC) proving unemployment status and the amount of unemployment compensation being received.
- Alimony or Child Support Agreement
- Bank statement (only if it shows a direct deposit)
- Official Paperwork: Paperwork documenting retirement, disability, SSI benefits.
- If homeless: Letter from shelter where you are getting services
- If homeless/doubling up: Doubling up verification form
- If completely supported by a friend/relative, signed letter of support from that person

Complete and sign the attached application and return to CCHC, along with proof of income prior to your next appointment:

Via email to financial.docs@cchc-clt.org
In person to Charlotte Community Health Clinic, 8401 Medical Plaza Dr, Suite 300, Charlotte, NC 28262
In person to Charlotte Community Health Clinic, 5301 Wilkinson Blvd, Charlotte, NC 28208

Revised 08.30.18
The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical, behavioral health and/or dental needs. **This form will not be used to withhold or deny services to you.**

1. Is any other family member applying for a discount with this application?  
   - [ ] Yes  
   - [ ] No

2. Are you covered under Medicaid, Medicare or any other insurance?  
   - [ ] Yes  
   - [ ] No

3. If you have private insurance, what is your annual deductible, per family member?  
   - $_____

4. Are you unemployed?  
   - [ ] Yes  
   - [ ] No

5. Are you too sick to work or are you disabled?  
   - [ ] Yes  
   - [ ] No

**TO BE COMPLETED BY PATIENT/GUARDIAN:** Please include yourself, your spouse/partner, children and everyone else living in the home.

*See attached list for acceptable forms for proof of income and household members

<table>
<thead>
<tr>
<th>Name*</th>
<th>Relation in Family</th>
<th>Date of Birth</th>
<th>Income</th>
<th>Frequency</th>
<th>Proof of Income*</th>
<th>Health insurance plans by which you are covered</th>
<th>Annual Deductible</th>
<th>Applying for Assistance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: John Doe</td>
<td>Self</td>
<td>5/16/46</td>
<td>$346</td>
<td>weekly</td>
<td>Tax Form</td>
<td>Medicare</td>
<td>None</td>
<td>Yes</td>
</tr>
</tbody>
</table>

I have attached proof of income for the amounts listed above  
- [ ] Yes  
- [ ] No

** ***Documentation must be provided by patient or guardian to determine eligibility for Sliding Fee Scale***

I understand that the information I provide on this form is subject to verification by Charlotte Community Health Clinic. I certify that the above information is true and correct to the best of my knowledge and that I understand & agree that providing false information can result in me being denied ability to apply for the program; furthermore I agree to adhere to all terms and conditions of the Sliding Fee Discount Program. I will report any changes of the above information to CCHC. **I also understand that I must supply proof of income before my next visit, or I will have to pay the full price with no discount.**

______________________________  __________________________  ________________
Patient/Guardian Signature  Printed Name  Date

Revised 08.30.18