HEALTH SERVICE ALLIANCE: Sliding Fee Scale Program Application (Rev 4/2019)

It is the policy of Health Service Alliance (HSA) to provide essential services even if the patient cannot pay. Discounts are offered based upon family income and size. The discount will apply to all services received at this clinic, but not those services which are provided from outside programs, including reference laboratory testing, drugs, x-ray results completed by a radiologist, and other such services*. If you feel this discount may be helpful to you and your family, you will need to complete the Sliding Fee Scale Program (SFDP) application and provide proof of income.

Medical /Behavioral Health Application: ☐ Dental Application: ☐

Information of Person Applying for Discount (Applicant):

Last Name	First Name	Date of Birth	Social Security #
Street Address		City, Zip Code	Phone #

Household Information: ***Please Note-if the household income is incomplete or inaccurate, the fee discount cannot be offered.***

Total # of Persons Living in Home:	**Total Monthly Income for all Persons: $**
List all sources of Income (see examples below):	

Types of Income Included:

1. **Government:** Social Security, SSI, Disability, Public Assistance, Temporary Assistance for Needy Families, Survivor Benefits, Veterans Benefits
2. **Job-Related**: Employment, Unemployment, Workers Compensation, Pension
3. **Other**: Retirement Income, Dividends, Rental fees, Royalties, Alimony, Child Support, Education Assistance, or any other source of cash assistance.

Types of Income Not Included:

1. Non-cash Benefits such as Food Stamps and Housing Subsidies
2. Capital Gains or Losses

To be completed by HSA Staff/Administration:

Eligible for Nominal Fee: ☐ Yes ☐ No Eligible for SFDP Fee: ☐ Yes ☐ No Discount %: _______

Administrative Review:
Applicant has been approved for adjusted administrative fee: ☐ Yes ☐ No; Amount: $ ______________

Administrator Name: ____ Date: ______________________

Signature: ____

Applicant Acknowledgement:

By signing this form, I understand and agree with the following (initial all that apply):

____ I have been offered to apply for a sliding scale fee but have declined and am not eligible for a discounted fee.

____ I am not eligible for the discounted fee and am able to pay for my care through other means, such as insurance.

____ I have been made aware that some services may have a separate discounted fee charge and I will be notified at the time that the services, equipment or medications are recommended*.

____ I have been notified that I am eligible for a sliding scale fee in the amount of $ _____ __for Medical/Behavioral Health and/or $ _______ for Dental services, and I am able to pay this fee(s) for my care. I will notify HSA if at any time I become unable to pay this amount.

____ I have been notified that I am eligible for a sliding scale fee in the amount of $ _______but am unable to pay this amount. I request administrative review for a possible fee adjustment.

____ I give permission for HSA staff to contact each employer or agency listed to confirm my income.

____ I will provide or have provided HSA staff with proof of income documentation.

____ I am unable to provide proof of income documentation as my employer does not provide check stubs, and it is not possible for the person(s) who pay me to write a letter to prove my earnings.

____ I will be asked to re-apply for this program every year.

____ I will notify HSA any time there is a change in my income, household size or insurance coverage.

____ I will pay my fee at the time that services are provided.

____ I certify that all information I have provided is correct and complete to the best of my ability.

Patient/Applicant's Signature: ____________________________________ Date: __________________

If needing to mail in application and/or proof of income, please mail to:
HSA, 5050 San Bernardino St., Montclair, CA 91763