Eligibility Determination for Sliding Fee Discounts

It is Ironbound Community Health Center, Inc. (ICHC) policy to provide essential services to all patients regardless of the patients ability to pay. Discounts are set by the ICHC consumer Board of Directors and are offered based on the information you provide regarding your family size and income. If you are eligible for a sliding fee discount, it will apply to all services received at ICHC, but not for those services provided outside the Health Center.

Please complete the following information, even if you have insurance.

Household Income Before Taxes

HOUSEHOLD MEMBER	MONTHLY INCOME	YEARLY INCOME
Self Name:		
Spouse Dependent Children		
Other dependents **Total**		

☐ I am declining to provide information on my income and family size and agree to pay the full ICHC fee.

ACCEPTABLE PROOF OF INCOME IS REQUIRED FOR THE SLIDING FEE DISCOUNT PROGRAM. IF YOUR FINANCIAL SITUATION CHANGES, PLEASE KEEP ICHC INFORMED.

☐ I certify that all information shown above is true, accurate and correct. I understand that if ICHC determines that I misrepresented or falsified information, I will no longer receive discounts and may be asked to pay back discounts provided.

☐ I agree to provide documentation of my income at my next visit.

Name (print)______________________________ Signature: ________________________________

Witness:__________________________________ Date: ____________________________________

Staff to complete information below

1. Eligible for Sliding Fee Discount:	Yes	No	Patient Refused
2. If yes, acceptable proof of income provided:	Yes	No	Patient Refused
3. If insured, Health insurance card provided:	Yes	No	Not applicable _____
4. Patient reports no income	Yes		
5. Patient is unable to obtain proof from an employer (This includes paid in cash/off the books earnings)	Yes		