healthcare network

Sliding Fee Application

Patient ID:

Name: _____

DOB: _____ EHR ID: _____

Or attach ID Label

Head of Household Information / Responsible Party

Last Name	First Name:		Date of birth

Address:	City:	State:	Zip Code:	Phone:

Place of Employment:	Phone:	Self Employed?	
		Yes ( )	No ( )

Please list spouse and dependents under age 18 (including yourself)

	Name	DOB	Income? (Circle one)	
Self			yes	no
Spouse			yes	no
Dependent			yes	no
Dependent			yes	no
Dependent			yes	no
Dependent			yes	no
Dependent			yes	no
Dependent			yes	no
Dependent			yes	no
Dependent			yes	no

Household Income

Documentation of you and your household's income must be attached to this application pursuant to our sliding fee scale policy. Please check with a member of our staff if you have questions regarding what documentation is necessary. Our staff will calculate the annual household income from the documentation you provide and will tell you which slide you qualify for, if any. If you have any questions regarding your annual household income please check with a member of our staff. By signing this application you are certifying that you have provided **all** income information relevant to this application and your household's annual income and are attesting to its authenticity.

Verification Checklist (attach copies) – For Office Staff Use Only	Yes	No
Identification/Address: Driver's License, Birth Certificate, Employment ID, Valid Florida ID, or Other Photo ID		
Income: Prior Year Tax Return, four weekly or two bi-weekly most recent pay stubs, letter of support, letter of		
Is patient applying due to Health Insurance Non-Covered Services or Out of Network Services?		

I certify that I have received and verified all the information and documents provided that are required to complete this application.

Annual Income: $			
Processed by(Athena/Denticon Login):	Pay Scale Approved:	Effective:	Expires:
Verified by:	Initials:	Date:	

Attestation/Signature

I/We hereby apply for financial assistance for services rendered by Collier Health Services, Inc., d/b/a Healthcare Network ("HCN") and certify that the information provided by me/us and contained herein is true and accurate to the best of my/our knowledge. I/We hereby give consent to HCN to verify all statements made on this application and documentation contained herein. I/We understand that intentionally making a false statement on this form is a crime punishable under Florida law. I/We accept and understand the requirement to re-determine eligibility before expiration date and/or if the information provided changes. I/We agree to payment responsibilities, and that minimum fees vary depending on the type of services I/We receive from HCN.

_____ Name (Print)

_____ Signature/Date