HEART OF FLORIDA HEALTH CENTER
SLIDING FEE APPLICATION

Heart of Florida Health Center is a Non-Profit Organization that receives a defined amount of Federal funding to supplement the cost of providing Medical/Dental care to patients who are eligible to participate in the sliding fee scale program. Eligible patients will also qualify for reduced cost prescriptions. To determine your eligibility for this federally funded program, verification of your income is required. **You must update this information at least annually to continue your participation in the program. This information is only used to calculate your discount and is kept confidential.**

Patient Name: _____Social Security_____-____-_____DOB___-___-____

I would like to apply for Heart of Florida Health Center Sliding Fee: ☐Yes ☐No

Household Size # of Adults _____ #of Children_____ Total # _____

A Household constitutes any group of individuals, with or without children, living under the same roof that pool resources for monthly expenses. Persons may or may not be related. Children if Full Time Students over 18 may be used if still claiming on annual income taxes.

List Below the Full Name of members in the household and their Date of Birth

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Documentation Required for Sliding Fee: These are due within 30days of Application or Placed Over Income

1. **Pay Stubs (Household's pay stubs for most recent 4 weeks)**
2. **Employer Letter (If paid in Cash)**
3. **Unemployment Benefit Summary Letter**
4. **Copy of Tax Records, Bank Statements, Self-Declaration Form**
5. **Other (Veterans, Social Security, Pension Benefits, Child/Alimony, Workman's Comp)**
6. **No Income - Provide a Notarized letter from person you know (not related) verifying you have no income and stating your living arrangements (food/shelter)**
7. **Food Stamp or Medicaid Eligibility Letter**
8. **Proof of Identity (Government Issue ID, Current DL, School ID, Birth Certificate)**

I Certify that my total Household income is $_____/Monthly or $_____/Yearly

INTAKE ACKNOWLEDGEMENTS

I have answered all questions truthfully, completely and to the best of my ability; including dollar amounts. I understand that failure to do so may result in denial of eligibility to receive services. I agree that Heart of Florida Health Center may verify this information through the use of a third party vendor. The facility, its employees, officers and practitioners are hereby released from any legal responsibility or liability for disclosures as indicated and authorized herein.

Signature:_____Date:_____

Office Use Only

☐Pay Stub ☐Copy of Taxes ☐Notarized Letter ☐Employer Letter ☐Medicaid Eligibility Letter ☐Other (Social Security/Pension ☐Unemployment Benefit Letter ☐Other Notarized Letters ☐Child/Alimony ☐Workman's Comp ☐Other Income ☐Bank Statements ☐Self-Declaration Form

Effective Date _____Renewal Date_____ SFS A-B-C-D-E-OI Approved by_____ Date_____