SLIDING FEE APPLICATION (ANNUAL SUBMISSION REQUIRED)

Patient Name: _____ **Date of Birth (MM/DD/YYYY):** ____/____/_____

Household Information

Who lives in your household?
(Include yourself, spouse/partner, and dependents you support.)

Total Household Size: _____

Household Income

What is your total household income?
(Include wages, benefits, and other income sources.)
Examples: paychecks, Soc. Sec., disability, unemployment, or other income

Amount: $_____

☐ **Weekly**
☐ **Bi-weekly**
☐ **Monthly**
☐ **Annually**

Income Verification

☐ **I have income AND I am providing proof today**. *(The final rate of the discount program will be applied.)*

☐ **I have income, but I cannot provide proof today.** *(The minimum rate will be applied for now. You must provide proof within 30 days, or you may be charged the full rate.)*

Self-Declaration without Proof of Income: I declare that my household has income, but I cannot present proof at this time. I confirm that the information written above is correct to the best of my knowledge. I understand that this declaration gives me temporary access to the Discount Program.

Patient or guardian initials: _____

☐ **My household income is $0**

No-Income Declaration: I certify that my household currently does **not receive income from any source.** Check what describes your situation:

- ☐ I am Unemployed
- ☐ Temporary or seasonal work
- ☐ I receive support from family or friends
- ☐ I receive support from an agency or program. Program name: _____
- ☐ Other: _____

Patient or guardian initials: _____

Acknowledgments & Responsibilities

I understand that:

• Eligibility for the Sliding Fee Discount Program is based on household income and size and applies only to eligible services.
• Eligibility may change if my household income or size changes, and I am responsible for notifying Heart of Florida Health Center of any changes.

Patient Attestation & Signature

I certify that the information provided on this application is **true and complete** to the best of my knowledge. I understand that providing false or incomplete information may result in **loss of eligibility** for the Sliding Fee Discount Program. I understand that this application must be **renewed annually**, or sooner if my financial situation changes.

Patient / Responsible Party Signature: _____
Printed Name: _____
Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian
Date: ___ / ___ / _____

Staff Use Only
Slide Assigned: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F
Docs Reviewed: ☐ Yes ☐ No
Effective Date: _____
Staff Initials: _____