CONTENTNEA HEALTH
SLIDING FEE DISCOUNT PROGRAM APPLICATION

Please complete this application to apply for the sliding fee scale discount program. Make sure you answer all questions to avoid delays in your application being processed.		TODAY'S DATE
FIRST NAME	MIDDLE NAME	LAST NAME
DATE OF BIRTH	PHONE NUMBER	EMAIL ADDRESS

Declination Statement (Only check this box if you DO NOT want to apply for the Sliding Fee Discount Program and sign the form.)

☐ I do not wish to apply for the Sliding Fee Discount Program at this time. I understand I may apply any time in the future.

How can we contact you about your eligibility for the Sliding Fee Discount Program?

Can we contact you by cell phone and email about your eligibility for the Sliding Fee Discount Program?

☐ Yes ☐ No

Where do you receive your mail?

MAILING ADDRESS		
CITY	STATE	ZIP CODE

Please answer the following questions about your housing:

Do you live in public housing;	☐ Yes ☐ No
Are you homeless?	☐ Yes ☐ No
If you are homeless, where are you currently sleeping?	☐ Shelter ☐ Family Member ☐ Friend ☐ Street ☐ Other

Please answer the following questions about your employment status:

Are you employed?	☐ Yes ☐ No – I am unemployed. ☐ No – I am retired.
If you are employed, where do you work?	
If you are unemployed, do you receive unemployment benefits?	☐ Yes ☐ No
Do you receive Social Security benefits?	☐ Yes ☐ No
Do you receive retirement income?	☐ Yes ☐ No
Do you receive any type of public assistance (i.e. TANF, SNAP, Work First)?	☐ Yes ☐ No
Do you receive alimony and/or child support?	☐ Yes ☐ No
Are you a full-time student?	☐ Yes ☐ No
Are you a seasonal or farm worker?	☐ Yes ☐ No

Who is your head of household?

☐ Self - I am the head of household.		
☐ Someone other than myself. (Provide head of household information below.)		
HEAD OF HOUSEHOLD FIRST NAME	HEAD OF HOUSEHOLD MIDDLE NAME	HEAD OF HOUSEHOLD LAST NAME
HEAD OF HOUSEHOLD DATE OF BIRTH	Is your head of household a patient at Contentnea Health? ☐ Yes ☐ No ☐ Don't Know	

Tell us your family size.

How many people (including yourself) receive more than half of their financial support from your household?	FAMILY SIZE #

Tell us about your family and household income.

SELF (YOUR NAME)	AGE	EMPLOYER/INCOME SOURCE ☐ No Income	MONTHLY INCOME $
HEAD OF HOUSEHOLD (IF DIFFERENT FROM SELF)	AGE	EMPLOYER/INCOME SOURCE ☐ No Income	MONTHLY INCOME $
FAMILY MEMBER NAME	AGE	EMPLOYER/INCOME SOURCE ☐ No Income	MONTHLY INCOME $
FAMILY MEMBER NAME	AGE	EMPLOYER/INCOME SOURCE ☐ No Income	MONTHLY INCOME $
FAMILY MEMBER NAME	AGE	EMPLOYER/INCOME SOURCE ☐ No Income	MONTHLY INCOME $
FAMILY MEMBER NAME	AGE	EMPLOYER/INCOME SOURCE ☐ No Income	MONTHLY INCOME $

Certification Statement

I certify that the information provided in this application is true and accurate to the best of my knowledge. I understand that Contentnea Health will keep this information private and confidential.

I also understand that general, non-personal information—such as income levels and the percentage of patients who qualify for discounts—may be shared with the U.S. Department of Health and Human Services (DHHS) Health Resources and Services Administration (HRSA) for reporting purposes.

No personal or identifying information will be shared.

I understand that I am responsible for notifying Contentnea Health if my family size or income changes.

Applicant/Patient Signature

Signature Date

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PATIENT ATTESTATION	☐ None ☐ 30 Day GP ☐ Income Attest ☐ 0 Income	ANNUAL INCOME	$	FAMILY SIZE	
ELIGIBILITY DETERMINATION	☐ A ☐ B ☐ C ☐ D ☐ E	INCOME VERIFICATION	☐ Patient Attested ☐ Verified via Income Docs ☐ Unverified		
ELIGIBILITY PERIOD	☐ 30 Days ☐ 90 Days ☐ 365 Days ☐ N/A	BEGIN DATE		END DATE	
Processed By		Process Date		Patient Account Number	