Today's Date:________________
Account #:________________

GREENE COUNTY HEALTH CARE INC
SLIDING FEE PROGRAM APPLICATION

Patient's Name:		**Date of Birth:**
Address:		**County:**
City:	**State:**	**Zip:**
SSN:	**Home/Cell Phone:**	**Email:**

Do you have medical insurance coverage:	Yes ☐	No ☐	*If yes, please present your insurance card to the receptionist. This does not affect your eligibility for sliding fee.*
Do you have dental insurance coverage:	Yes ☐	No ☐	

For the purpose of this application family is a group of individuals, related or unrelated, living together or separately, that are supported by the same income resources. Do not include individuals living with you who have their own income and are not dependent on the income of the individuals listed on this application.

	Family Member Name:	**Relationship to you:**	**Date of Birth:**	**Employer:**	**Income & How Often-Week, Biweekly, Annual:**
1					
2					
3					
4					
5					
6					
7					
8					
9					

Revised 12/18

The discount you qualify for is based on federal poverty guidelines and is good for all services received at any Greene County Health Care facility for one year from the date of qualification. However, certain services have a different schedule of discounts based on supplies and equipment involved (for example, dentures, crowns and bridges, IUDs, etc.). If you have a question about the discount or a specific service, please ask the receptionist.

By signing this application you acknowledge the following:

- You must provide acceptable proof of income including the last two paystubs and/or the most recently filed tax return for all family members on the application.
- You must notify us within 30 days of changes to your address, phone number, family size, income or insurance status.
- You give consent to contact your employer to verify information concerning your income if needed.
- If you qualify for the sliding fee program, you must complete a new application and requalify annually.

I attest with my signature below that all information provided is true and accurate and I agree to abide by the conditions of the sliding fee program as listed above.	
Signature	***Date***

For internal use only:

Account #:	Application Date:	Ending Date:
Family Size *(patient + family members):*	Income:	Per (cirle one): Year Week Month
Qualifies: YES NO	Sliding Fee: A B C D	Staff Initials: