InterCare Community Health Network

SLIDING FEE APPLICATION AND CERTIFICATION

InterCare Community Health Network

InterCare Community Health Network offers adjusted fees for certain medical and dental services provided in our health centers. Eligibility is determined by a method that considers your family size & income. InterCare will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap or political beliefs.

HEAD of HOUSEHOLD Information ONLY (Head of Household may or may not be the patient)

Name: _____ Social Security # : __ __ __-__ __-__ __ __ __ Date of Birth : _____

Address:_____ (☐ same as patient) City:_____ Zip Code:_____ Sex: ☐ Male ☐ Female

Do you have Insurance? ☐ No Medical ☐ Medicaid ☐ Medicare ☐ Private Insurance (Ca: _____) ☐ No Dental ☐ Dental: _____

Preferred Phone: _____ (☐ Cell ☐ Home) Language : _____

Family Size and Income per Family Member (List all people who are supported by Head of Household)

Name	Relation	Birth Date	InterCare patient	Income	* Per:	** Source:	Notes/Adjustments/Calculations	Total Annual
1			☐					
2			☐					
3			☐					
4			☐					
5			☐					
6			☐					
7			☐					
8			☐					
Total Family Size = _____							**Total Annual Family Income =**	

I, Head of Household, certify that these statements are true and correct.
I authorize InterCare Community Health Network to verify my income stated above.

Applicant's Signature: _____ ***Date***: _____

Employee Review: _____ Date: _____

** ***FOR OFFICE USE ONLY***

Income Documentation on File: ☐ Self Declaration ☐ Proof of Income _____(date)

Verified by: _____ Date: _____ SF Extension Verified by: _____ Date: _____ Ext.#:____
(Employee Initials) *(Employee Initials)*

Permanent Self-Declaration granted for current year. Approved by: _____ Date: _____
(Manager/Designee Initials)

AD 10 E/S (Revised 9/22) This form was scanned into Account #: _____

*** Per:**	**W** = Weekly	**B** = Biweekly	**A** = Annually
	M = Monthly	**S** = Semi-Monthly	

**** Source:**	**W** = Wages, Salary, and/or Tips		
	U = Unemployment Benefits		
	B = State Assistance		
	S = Social Security		
	C = Child Support		
	R = Rent	**I** = Interest	**O** = Other

InterCare Community Health Network

SOLICITUD DE TARIFAS REDUCIDAS Y CERTIFICACIÓN

InterCare Community Health Network

InterCare Community Health Network ofrece tarifas ajustadas para ciertos servicios médicos y dentales proporcionados en nuestros centros de salud. La elegibilidad se determina por un método que considera el tamaño e ingreso de su familia. InterCare no discriminará contra cualquier individuo o grupo por raza, sexo, religión, edad, origen nacional, color, estado civil, incapacidad o creencias políticas.

Información de CABEZA de FAMILIA SOLAMENTE (cabeza de familia puede ser o no el paciente)

Nombre: _____ Número de Seguro Social : __ __ __-__ __-__ __ __ __ Fecha de nacimiento : _____

Dirección: _____ (☐ igual que el paciente) Ciudad: :_____ Código Postal:_____ Sexo: ☐ Masculino ☐ Femenino

¿Tiene seguro? ☐ No Médico ☐ Medicaid ☐ Medicare ☐ compañía de seguro medico privado: _____ ☐ No Dental ☐ Dental: _____

Teléfono de preferencia: _____ Idioma : _____

Tamaño e Ingreso Familiar por Miembro de la Familia (enumere a todas las personas que son mantenidas por el cabeza de familia)

Nombre	Relación	Fecha de nacimiento	InterCare patient	Ingreso	* Por:	** Fuente:	Notas/Ajustes/Cálculos	Total Anual
1			☐					
2			☐					
3			☐					
4			☐					
5			☐					
6			☐					
7			☐					
8			☐					
Tamaño familiar total = _____							**Ingreso familiar anual total =**	

Yo, el/la Cabeza de Familia, certifico que estas declaraciones son verdaderas y precisas.
Autorizo a InterCare Community Health Network que verifique mi ingreso declarado arriba.

Firma del solicitante: _____ ***Fecha***: _____

Employee Review: _____ Date:_____

* Per:			
	W = cada semana	**B** = cada dos semanas	**A** = anualmente
	M = cada mes	**S** = dos veces al mes	

** Source:			
	W = sueldo, salario, y/o propinas		
	U = beneficios por desempleo		
	B = asistencia del estado		
	S = seguro social		
	C = manutención de niños		
	R = alquiler	**I** = interés	**O** = otro

** ***FOR OFFICE USE ONLY***

Income Documentation on File: ☐ Self Declaration ☐ Proof of Income _____(date)

Verified by: _____ Date: _____ SF Extension Verified by: _____ Date: _____ Ext.#:____
(Employee Initials) *(Employee Initials)*

Permanent Self-Declaration granted for current year. Approved by: _____ Date: _____
(Manager/Designee Initials)

 This form was scanned into Account #: _____