MONTEREY COUNTY HEALTH DEPARTMENT CLINIC SERVICES DIVISION

Seaside Family Health _____ Monterey County Clinic at Marina____ Alisal Health Clinic____ Public Health Clinics ___
Laurel Clinics: Laurel Vista ____ Family Practice_____ Pediatric Clinic_____ Internal Medicine Clinic ____

APPLICATION for the SLIDING SCALE DISCOUNT FEE PROGRAM

******* Proof of income *must* be attached to this form *******

Please read and fill out this form completely, answer all questions and sign the affidavit on the back side of this page. ✸*If this application in incomplete, it will be sent back or denied.*✸

PATIENT NAME ↓	Birth Date ↓	Social Security Number ↓	PHONE ↓

ADDRESS ↓	CITY ↓	ZIP CODE ↓

Mailing Address if different from physical address ↓	CITY ↓	ZIP CODE ↓

Patient's Employer or Source of Income or Provider's Name: _____
Is the patient a U.S. Citizen or Resident? Yes ____ No ____

Patient's Family members(s) that live with patient at the above address ↓	**Date of Birth ↓**	**Relationship to Patient ↓**	**Name of Employer or Type of Income Received or For minors: Name of School in attendance**

What is your family's total gross income per month/year? _____ month / year
What is your monthly rent or mortgage? _____ rent / mortgage
Do you currently have health insurance coverage? _____ if yes, with whom? _____

One month's proof of family income must be provided to the Health Center within 30 days from the office visit. Discounts are good for one year and may be renewed after that time period only if you have an appointment. (Letter of support is NOT acceptable.) Acceptable proof of income may be:

- Current Year Federal Income Tax Return (the 1040 form page 1 & 2) or W-2's (current year)
- Copies of check stubs (for one month) less than 30 days old
- Alimony checks (court ordered or a written letter by the parent paying the alimony) less than 30 days old.
- Workers Compensation, SDI, SSI (Social Security Disability) or unemployment benefits
- Social Security retirement check or conformation letter or verification of direct deposit
- Other private or employer pension check stubs
- Signed Statement from employer (if wages paid in cash)
- Assistants' Statement from Dept. of Social Services (Cal Works, Cal Fresh, General Assistance)
- If someone provides for you the patient, we need his/hers proof of income.

Over →

All information you give is confidential and this is a voluntary program.

U.S. Resident Aliens under sponsorship are not eligible for this program. The patient's sponsor is responsible for the patient's medical services and charges.

Adults that are U.S. citizens or legal residents from 21 to 64 years old whose income fall at or below 138% of the federal poverty level (FPL) are presumed eligible to Medi-Cal under the Affordable Car Act (ACA) and are encouraged to apply at the Department of Social and Employment Services (DSES).

AFFIDAVIT

I understand that the medical services I am receiving today will be billed to me at 100% of the cost of the services provided. I understand that total family income and size will determine the discount I may be eligible for, if any. (The Federal Poverty Level table is used to determine eligibility and discount.)

I understand that certain services, procedures or vaccines are limited and may not be covered under this program. (Immunization-only visits and 3rd party liability, etc. are not covered.)

If I provide the clinic with proof of my family income (applicants, spouse's, parent of the patient, or any family member or friend that is a provider to the patient) and the income is within the Sliding Scale Fee guidelines, fees for services may be reduced.

I certify under penalty of law that the above information is correct.

_____ _____

Patient or Responsible Party Signature **Date**

Applications may be mailed to the billing office at:
Attention: SSDF Program,
Clinic Services Division,
1615 Bunker Hill Way, Ste.100,
Salinas, CA 93906

For Office Use Only

Approved:_____ Denied: _____ (date)_____ Reason: _____ By:_____ DISCOUNT:_____
Application Received: ____/____/____ Approved: ____/_____/_____ By:_____ CARD #_____