Alliance Community Healthcare Sliding Fee Application

Patient Information		
Today's Date:	Name of Applicant:	
Date of Birth:	Telephone #:	
Address		
City:	State:	Zip Code:

Family Size	
What is the number of people in your family size (including yourself)?	

Income: Please provide the Annual Income for each of the people in your family size (including yourself).

Name	Relationship	Date of Birth	Income Type (Source)	Annual Income $
1.				
2.				
3.				
4.				
5.				
6.				
Total Income				**$**

Insurance Information	
Do you have any type of insurance that will cover all or a portion of your medical expenses? ☐ **Yes** ☐ **No**	
Insurance Name	**Policy/ID#**
Insurance Name	**Policy/ID#**
I declare under penalty of perjury that the above information is true and correct, and I give Alliance Community Healthcare permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income or "family size" should change, I am required to notify Alliance on my next visit to the health center. All the members included above in your family size are automatically approved in ACH's SFDP once you have been approved.	
Applicant Signature:	**Date:**

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Reviewed By:_____ Verified Income/or Self-declaration on:_____

Patient & family members are eligible for SFD Tier: ☐A ☐B ☐C ☐D ☐E (100% of Charges)

Eligibility start date: _____ and expires (1) One Year from Eligibility Date.