Sliding Fee Scale Eligibility Declaration
We are an equal opportunity provider
No patient will be declined services based on an inability to pay

Applications will not be accepted unless form is completed and proof of income is provided

____
Name (Head of Household)

____
Physical Address City State Zip Code

____
Mailing Address (If different from above) City State Zip Code

Primary Phone (______) _____________________ Other or Message Phone (______) __________________________

Proof of Income Verification - The following list are types of proof that can be used for verification: Paycheck stubs (minimum of one month, preferably three months) Statement from employer as to proof of wages (when check stubs are not used).

Pay Stubs – minimum one month	Most recent Tax Return
Statement from unemployment services, SSI or food stamps	Self-Declaration/Social Declaration (may be filled out below)
Statement of income determination from the Department of Housing	Recent Bank Statement showing income deposits
Annual W-2 wage statements from all income sources	

Household Information (must be completed for all household members)
Number of Household Members: ______

		Office Use Only	
		Proof of Income	MRN
1. Name: ________________________	**Date of Birth:** ___/___/___	Y/N	________________________
2. Name: ________________________	**Date of Birth:** ___/___/___	Y/N	________________________
3. Name: ________________________	**Date of Birth:** ___/___/___	Y/N	________________________
4. Name: ________________________	**Date of Birth:** ___/___/___	Y/N	________________________
5. Name: ________________________	**Date of Birth:** ___/___/___	Y/N	________________________

*Additional family members may be added to the back of this form

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Self-Declaration/Social Declaration – *To be completed only if you have no income or your income cannot be verified*
Source of Income (Name of Employer or other income source): ____

Gross Monthly Earnings for **Household** (before taxes): $________________
How often do you receive the above income? Daily ____ Weekly ____ Bi-Weekly ____ Bi-Monthly ____ Monthly ____
Has your housing changed dramatically in the past year? Yes ____ No ____
If so, please explain: ____
____

Sliding Fee Scale approval for unverified or lack of income will be granted for 30 days.

WE ENCOURAGE APPLICANTS TO MEET WITH OUR OUTREACH STAFF TO DETERMINE WHETHER YOU OR ANY HOUSEHOLD MEMBERS MAY QUALIFY FOR THE OREGON HEALTH PLAN.

ATTESTATION: *BY SIGNING BELOW, I ATTEST THAT, AS OF THE DATE OF MY SIGNATURE, THE INCOME SOURCES LISTED CONSTITUTE ALL OF MY HOUSEHOLD INCOME, AND THAT THE HOUSEHOLD MEMBERS LISTED ARE ALL SOLELY DEPENDENT ON THAT INCOME, OR THAT THE EXPLANATION PROVIDED TO VERIFY MY INCOME LEVEL IS TRUTHFUL.*

Applicant Signature: ____ Date: __________________________

Office Use Only

A: $25 visit **B: $30 visit + 25% procedures done by LCHC** **C: $35 visit + 50% procedures done by LCHC**
D: $40 visit + 75% procedures done by LCHC **E: 25% discount for full payment at time of services**

Total Yearly Earnings: $__________________ **Effective Dates:** _______________________ **thru** _________________________

Employee Signature: ____ **Date:** _________________

S:LCHC Forms/Check in Packets/SFS/Sliding Fee Scale Application 11-2017