KNOX COMMUNITY HEALTH CENTER

1361 West Fremont Street ▪ Galesburg, IL 61401 ▪ 309.344.2225 ▪ knoxcountyhealth.org

Sliding Fee Scale Program Application

ALL INFORMATION YOU PROVIDE IS KEPT CONFIDENTIAL (PRIVATE)!

Name: _____ **Date of Birth:** _____

Marital Status: _____ **Phone Number:** _____

Mailing Address: _____

Where you live, if different from mailing address: _____

Employer Name: _____

Total Number of Persons in Your Household (Family Size): _____

Information about applying for the Program:

- This Sliding Fee Scale Program application must be completed in its entirety.
- If you do not have an employer or income, write "none," and complete the **STATEMENT OF SUPPORT FOR APPLICANTS WITH NO INCOME FORM.**
- If you have an employer and income but are unable to provide the proof listed in the Income Worksheet (page 3), complete the **PATIENT EMPLOYMENT VERIFICATION FORM.**
- Sliding Fee Scale Program Plans will be based only on household size and income. The Knox Community Health Center recognizes that families do not always fit the traditional model and has identified the definitions of household, family, and income as indicated below. This application applies to the individual completing the form and any household members included in the application. Please use the following information on **Household, Family, and Income** when completing the Members of Household Worksheet (page 2).
  - A. HOUSEHOLD consists of all persons who occupy a housing unit (a house, apartment, mobile home, group of rooms, or single room that is occupied as separate living quarters). Adult children living at home who are no longer dependent are considered a separate household. Roommates who share living arrangements; but are not tied to one another through marriage, children, or similar relationships are considered separate households. Those living with a friend or relative during a time of need, are also considered a separate household.
  - B. FAMILY is defined by the US Census Bureau, as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption, and residing together; all such people (including related subfamily members) are considered as member of one family.
  - C. INCOME includes wages and earnings (including self-employed), unemployment benefits, retirement pension, Social Security income, child support or alimony, public assistance, rental income, any short/long term disability, worker's compensation, or other income reported on Federal tax return. Earned income from working minor children under the age of 18 years is exempt. Noncash benefits such as SNAP benefits and/or housing subsidies do not count towards household income.

We're here to help! Monday through Friday from 7:00 a.m. to 5:00 p.m.
Call 309-344-2225 with any questions.

Our Outreach & Enrollment team can help you with these forms. We can also help you find health insurance options through the Illinois Health Insurance Marketplace.

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Members of Household Worksheet

First and Last Name	Date of Birth	Relationship to You Self, Spouse, Child, Parent, etc.	Gross Income Before Deductions (30 Days)	Income Source Job, Social Security, TANF, Child Support
See Income Worksheet on Page 3 for Income and Acceptable Proofs of Income				
1.				
2.				
3.				
4.				
5.				
6.				

Please list any additional household members on another sheet of paper.

MEDICAL AND/OR DENTAL INSURANCE INFORMATION

Is there any current medical insurance for you or any member of the household: ☐ YES ☐ NO
(This includes Medicaid, Medicare, and Private Insurance)

If yes, please provide the following information: REMEMBER, you can still qualify even with insurance

For Medicaid/Medicare coverage, please provide members name, date of birth, and social security number

_____
_____
_____
_____
_____
_____

For Private or Employer Provide Medical Insurance:
Name and Address of Insurance Company: _____
_____
Policy Number: _____ Group Number: _____
Insured Name: _____ Insured Date of Birth: _____

For Private or Employer Provided Dental Insurance:
Name and Address of Insurance Company: _____
_____
Policy Number: _____ Group Number: _____
Insured Name: _____ Insured Date of Birth: _____

Please attach a copy of your insurance card; if you are not able at this time, we will ask for it when you visit us.

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Income Worksheet

Please provide a copy of your most recent tax return or other income statements listed below.

If Anyone in Household Has…	✓	Amount Paid/How Often	You Must Provide Copies Of
Wages/Income from an employer	☐		One month of most recent paystubs OR most recent paystub with employee start date and year to date income amount listed, Patient Employment Verification Form (if nothing else available)
Self-Employment or Rental Income	☐		Last year's Federal Tax Return, Last three month's rental receipts for gross income, Patient Employment Verification Form (if nothing else available)
Social Security or Disability Income (SSI/SSDI)	☐		Current Year Award Letter or bank statement including patient name showing deposits
Retirement Pension/Benefits	☐		Benefit Letter or Statement showing gross amount distributed.
Unemployment Benefits	☐		Unemployment benefits award letter or bank statement including patient name showing deposits
Child Support or Alimony	☐		Copy of Court Order or bank statement including patient name showing deposits
Public Assistance/TANF	☐		Benefit Determination Letter or bank statement including patient name showing deposits
Short/Long Term Disability Benefits	☐		Most recent pay stubs showing gross income for disability benefits
Worker's Compensation Benefits	☐		Worker's Compensation benefits award letter showing gross distribution
Other Income Claimed on Federal Taxes	☐		Last year's Federal Tax Return, bank statement including patient name showing deposits, other
No Income	☐		Statement of Support for Applicants with No Income

I declare the above information is true and give the Knox Community Health Center (KCHC) permission to investigate any information provided in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the Patient Service Representative on my next visit to the community health center.

I hereby authorize payment to the KCHC and its contracted provider for usual and customary costs of treatment payable by any insurance I have; but, not to exceed KCHC schedule of charges. I understand that I am responsible to KCHC and its contracted providers for any charges not covered by any insurance I have.

Signature of Applicant **Date**

FOR OFFICIAL USE ONLY

I have reviewed this complete Sliding Fee Scale Program application and have made the following determination:

□ Patient is qualified for Sliding Fee Scale Program Plan _____
□ Patient **does not qualify** for the Sliding Fee Scale Program

Signature of Reviewer **Date**