Sliding Fee Discount Application

Riverbend Community Health (fictional sample organization)

Discounts are based on household size and income. Please complete every section and bring proof of income to your next visit.

1. Patient information

Patient name

Date of birth

Street address

City

ZIP code

Phone

2. Household

Number of people in household

Total annual household income ($)

3. Proof of income (check all you will bring)

☐ Pay stubs (last 30 days)

☐ Most recent tax return

☐ Signed statement of no income

4. Discount levels

Household income (% of poverty guidelines)	You pay
Up to 100%	$20 nominal fee
101% – 150%	40% of charges
151% – 200%	70% of charges
Over 200%	Full charges

5. Signature

Signature of patient or guardian

Date