Patient's Name: *First* *Last*	**Date of Birth**

Financial Information
Church Health serves all patients regardless of their ability to pay. We believe that money, or a lack of money, should never keep you from getting the care you need. However, as a patient of Church Health, you are responsible for the payment of all fees associated with your care. As a result, discounts for essential services are offered based on family size and income. By signing below, you agree to provide us with accurate information, now and in the future, and that you will attempt to pay your fees on the day you get your services. You may also choose to decline providing your financial information to us. However, by declining, you will not be eligible for income-based discounts, and you will be responsible for payment of the full fees associated with your care.
Proof of Income is required for all discounts.: **Before a discount can be arranged, we require that you provide written proof of your total household income. You may use current paycheck stubs, benefits check stubs, official letter of employment including compensation on company letterhead, a copy of your most recent federal 1040 tax forms, or a copy of applications for any other agency benefits (i.e. unemployment compensation letter, proof of alimony/child support, food stamp recertification letter) if they include household income.**

Patient's Signature (or legal guardian, if applicable) **X**	☐ I choose to decline sharing financial information

Household Income (include all income from persons included in the count below):			
Number of people living in your household (including you):			
Sources of Income	**You**	**Others in your home**	**Total**
Wages from Employment			
Self-Employment			
Other Sources of Income	**You**	**Others in your home**	**Total**
Social Security			
Public Assistance			
Pensions			
Rental Income			
Child Support/Alimony			
Other (specify)			
		Grand Total:	

Medical Sliding Fee Scale

Sliding Fee Scale Based On Family Size and Income Compared to Federal Poverty Level (FPL)

	Discount	-100%	-90%	-80%	-60%	-30%	0%
		At or below 100% FPL	101% to 150% FPL	151% to 200% FPL	201% to 235% FPL	236% to 295% FPL	Above 295 FPL +
Primary Care Provider Visits	**Nominal Fee**	$ 30	Greater of the discounted bill or $30				100%
Nurse, Lab, X-ray Only Visits	**Nominal Fee**	$ 15	Greater of the discounted bill or $15				100%
Urgent Care Clinic Visits	**Nominal Fee**	$ 40	Greater of the discounted bill or $40				100%