



One Day Sliding Fee Temporary Self Declaration

Unicare Community Health Center offers a Sliding Fee Discount Program for all low-income families living at or below 200% of the Federal Poverty Level. The program requires certain eligibility verifications be provided for a six (6) month approval. However, the program also offers a one-day presumptive eligibility pending completing the application process to assist families in receiving needed health care services.

You are being asked to complete this form in order to apply for the discount for today's visit because proof of income documentation/verification is unavailable. One-day sliding fee can only be issued twice in six (6) months pending the completion of a full application

Name: _____ Date of Birth _____ / _____ / _____

Address: _____ Zip Code _____

Phone Number: (_____) _____ Cell Phone: (_____) _____

Social Security # (Optional): _____ Employed ____ Yes ____ No Age _____

I have health insurance: ____ Yes ____ No Type: _____

My family income:

My family size:

____ I am applying for myself

____ I am including the following family members in my application _____

I declare that on this date I am not able to produce the requested documentation supporting a formal Sliding Fee application eligibility. I attest to the fact that the information I have provided is true. I understand that this form only applies to today's visit and will need to provide the required verifications to determine eligibility for one year. I understand that the unverified information I supply on this form does not guarantee that I will qualify for the same Sliding-Fee Scale Discount for future visits when my information is verified.

If any of the above information is false, I understand that I may be required to pay the reasonable value of the medical and/or diagnostic services rendered to me or members of my family.

Signature

Date

Sliding Fee Discount:

Approved for level _____ **Approved by:** _____