



UNICARE COMMUNITY HEALTH CENTER, INC. SLIDING FEE SCALE APPLICATION

____ I am not interested in disclosing my financial information; therefore, my family and I are not eligible for the sliding fee discount program.

____ I am interested in disclosing my financial information and being screened for the sliding fee discount program.

PATIENT INFORMATION		Today's Date: / /	
First Name:	Middle:	Last:	Date of Birth:
Phone Number:		Other names:	

FAMILY SIZE (INCLUDING YOURSELF)			
Name	Relationship	Date of Birth	Health Insurance if Enrolled
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

INCOME SOURCE: All family members with income must be included in the sources of income.

INCOME (PLEASE LIST YOUR GROSS INCOME – WHICH IS INCOME BEFORE TAXES AND DEDUCTIONS.)					
	You	Spouse	Children	Other	
Employment					
Social Security					
Public Assistance					
Retirement Pension					
Child Support, Alimony					
Other					
TOTAL	\$	\$	\$	\$	\$

INCOME VERIFICATION

- ☐ Attached is my income documentation– tax records, paystubs, employer letter, etc.
- ☐ I have other sources of income (Please check all that apply.)
- | | |
|---|--|
| ☐ I get paid in cash. | ☐ I am provided room and board by _____ |
| ☐ I am self-employed | ☐ I cannot get a letter from my employer. |
| ☐ I receive cash/gift U from _____ | ☐ I have rental property |



UNICARE COMMUNITY HEALTH CENTER, INC.

SLIDING FEE SCALE APPLICATION

PATIENT INFORMATION (Print)

First Name:	Middle:	Last:	Date of Birth:
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I certify that the information in this application is complete and correct. If any of the above information is false, untrue, misleading or incomplete. I understand that I may be required to pay full price for the services received according to the established fee schedule. I further agree to inform Unicare Community Health Center if there is a significant change in my income. If acceptance to the sliding fee discount program is obtained under this application, I agree to abide by the requirements of the discount program and consent to the release of any and all information needed to substantiate the eligibility information should it be necessary. I hereby acknowledge that I have read and understand the foregoing disclosure.

SIGNATURE

DATE

INTERNAL USE ONLY

Income verification using (Circle One):

Previous Year Tax Return

Payroll Check Stubs

Proof of Social Security
benefits (or other benefits)

Self-Attestation Form

Employer Letter

Other (Specify): _____

Annual Gross Income Calculations:

1. Paycheck stubs (3 pay periods preferred) Weekly – Average x 52 weeks \$ _____
Biweekly- Average x 26 \$ _____
Twice a month – Average x24 \$ _____

2. Previous Year Tax Return – Gross Income (line changes every year)

2025 1040 and 1040SR Line 11a \$ _____

2025 1099 (Total income lines) \$ _____

3. W2 - Check duration of employment and calculate is not annual - Line 1 – Wages \$ _____

4. Other – Check duration of benefit and calculate accordingly if not annual \$ _____

Eligible Family Size: _____ Total Gross Household Income: \$ _____ Scale: _____

REVIEWED BY: UCHC STAFF (SIGNATURE)

DATE

APPROVAL BY: OFFICE MANAGER (PRINT NAME)

SIGNATURE

REV. 04/20/2026