Cass County Health Clinic

Sliding Fee Discount Application

It is the policy of the Cass County Health/Dental Clinic (CCHC and CCDC) to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all Health and Dental Clinic services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

PATIENT NAME			HEAD OF HOUSEHOLD AND PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

Please list applicant and family members living in the household

Name	Date of Birth	Name	Date of Birth
Head of Household		Other	
Spouse /Other		Other	
Other		Other	
Other		Other	

Annual Household Income- Does not include non-cash benefits such as SNAP, school lunches, food/rent in lieu of wages, or housing assistance, the value of food or fuel produced and consumed on farms, value of rent from owner occupied housing, Medicare, Medicaid; capital gains, withdrawals from bank, sale of property, tax refunds, gifts, loans, lump sum inheritance, one time insurance payments, compensation for injury

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Net receipts from non-farm or farm self-employment				
Unemployment compensation, Social Security, Supplemental Security Income, veterans' payments, workers' compensation, Railroad Retirement, strike benefits, TANF				
Alimony, child support, military family allotments or other regular support from someone absent or not living in the household				
Private pensions, government employee pensions (including military retirement pay), regular insurance / annuity payments				
			Total Income	

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before discount is approved.

I certify that the family size and income information shown above is correct. Providing false information on this application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

Applicant Signature:_____ Date:_____

Office Use Only

Approved Discount: _____Approved By:_____Date:_____

Verification Checklist	Yes	No
Identification/Address: Driver's license, State issued ID, Passport, utility bill, employment ID, or other		
Income: Prior year tax return, one month income verification, or other		
Insurance: Insurance Cards		
Notes:		