Reason For Visit _____
How did you hear about New River Community Health Care Center:_____

Union County Health Department and New River Community Health Center
SLIDING FEE APPLICATION

The New River Community Health Center does not deny anyone services because of race, national origin, skin color, religion, sexual orientation, physical handicap, disability, source of payment, or the inability to pay and uses recent Federal Poverty Guidelines to establish a sliding fee scale for eligible low-income patients. If you would like to apply for our Sliding Fee Scale please complete the section below.

Patient Name: _____**DOB:** _____
Physical Address: _____
Mailing Address: _____
Social Security # _____ **Telephone:** _____
Driver's License or State ID #: _____**Exp. Date** _____
Ethnicity: (check one) **Non-Hispanic/Latino** **Hispanic/Latino** **Race:** _____

Are you a veteran of the United States Armed Services? Yes _____ No _____

Are you a Migrant Worker? Yes___ No ___ **Seasonal Agricultural Worker? Yes ___ No ___**

What is your language preference? _____ **Do you need an interpreter? Yes__No __**

If you would like to waive the eligibility process please initial here and sign at the bottom. _____ WAIVED

Family Members Name	DOB	Employer / Other		Gross Earned or Unearned Income
SELF				
SPOUSE				
		Child Support	Paid Received	
CHILD				
CHILD				
CHILD				
CHILD				
CHILD				

Child care expense per month for each child:	$ and Child's name	$ and Child's name	$ and Child's name	$ and Child's name

I certify that the information on this application is true and accurate. I also understand that falsifying information or documentation on this application will result in my application being denied and any applicable discounts received under false pretenses will be revoked and I will be responsible for all charges. I understand that by initialing to waive eligibility I am responsible for the **full fee** for services rendered. **I understand that I am financially responsible for payment of fees. Payment is due at the time services are rendered, unless prior arrangements have been made. Past due accounts may be referred to a collection agency.**

_____ _____ _____
SIGNATURE OF CLIENT/PARENT or GUARDIAN **SIGNATURE OF DEPARTMENT OF HEALTH EMPLOYEE** **DATE**

(VALID FOR 1 YEAR) Expiration Date:_____

DECLARATION OF INCOME / CONTRIBUTIONS
FOR CLIENTS DECLARING NO INCOME

1) How many people are in your family unit? _____
(A family is defined as 1 or more persons living in one dwelling place who are related by blood, marriage, law or have a joint child. To be considered a separate family unit, the individual must show he/she can provide for the majority of his/her living expenses.)

2) Do you receive food-stamps? **Y / N**
If yes, you must bring in a letter showing proof of food stamp benefits.

3) How much do you spend on groceries/other necessary items per month? **$**_____
If unknown, estimate a monthly cost of $200 per person in the family unit. $200 X ____ (# of people)

4) How much is your monthly rent or mortgage? **$**_____
If unknown, apply $100 per person in family unit. $ 100 X ___ (# of people)

5) Do you have a vehicle? **Y / N**

6) Do you have a car payment? **Y / N**
If so how much? **$**_____
How much do you pay for auto insurance monthly? **$**_____
How much do you estimate you use in gas monthly? **$**_____

7) Do you have a phone or access to a phone? **Y / N**
If yes to owning a phone, what is your monthly expense? **$**_____
If unknown, apply a minimum of $10.00.

8) How much is your monthly bill for utilities in the household? **$**_____
If living with others, divide the number of adults in household by monthly expense.
If unknown estimate $50.00 per month. $ _____÷ # of people.

9) How much do you spend monthly on clothing for the family? **$**_____

10) How much are your family medical expenses per month (i.e., medications)? **$**_____

TOTAL $ _____

I affirm that this information is true to the best of my knowledge and I hereby give Union County Health Department/New River Community Health Center permission to verify this information.

_____ _____
Client Signature Date Witness Signature Date

Living Quarters: ____Apartment ____House _____Mobile Home _____Car _____Camper _____Temp without shelter ____other
Number of rooms: _____ Method of Heat _____ Method of Cool _____
Check the working things you have:
_____ Refrigerator _____ Cooking Stove _____Hot Plate ____ Fan _____Indoor Toilet
_____Water inside for drinking _____ Water inside for bathing