ECO FAMILY HEALTH CENTER, INC.
Sliding Fee Discount Application

The following information is required for statistical purposes ONLY:

Name: _____ Date: _____

DOB: _____ # of Household Members: _____

Please check the category for your annual household income:

☐ Up to $15,060 ☐ Up to $22,590 ☐ Up to $30,120 ☐ $30,121 and Above

If you refuse to apply for sliding scale please check box and skip to Signature page. ☐

HOUSEHOLD INCOME FOR ALL HOUSEHOLD MEMBERS (Proof of income must be copied and attached)

Income Type: _____

How often are you paid? *(check one)* [ ] Weekly [ ] Bi-weekly [ ] Twice/monthly [ ] Monthly

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HOUSEHOLD MEMBERS:

_____ DOB _____ _____ DOB_____

_____ DOB _____ _____ DOB_____

_____ DOB _____ _____ DOB_____

_____ DOB _____ _____ DOB_____

_____ DOB _____ _____ DOB_____

Additional Important Information:

- The Front Desk Staff/Patient Representative will explain to the applicant the amount of fee reduction after they are qualified to receive the Sliding Fee Scale Discount.
- The application and income verification must be updated at least once per year.
- If any of the information on the application changes, please update with the Front Desk Staff/ Patient Representative. This includes income, persons living in the household, address, phone number, etc. This may change your Sliding Fee Scale Discount.
- Income verification must be submitted with Application.
- I understand that I am responsible for any charges above the allotted discount, including the nominal fee and any procedures, x-rays, lab tests or supplies that do not qualify for sliding fee discount.

You may submit the completed application with all required proof of income to any of our facilities (or mail them to: ECOFHC, PO Box 236, Wetumka, OK 74883).

I understand I do not qualify for a Sliding Fee Discount if my income is above 200% Federal Poverty Levels (FPL).

If the application is missing any of the above income information or is not signed, it will be denied. Incomplete applications will be considered void if all information is not received within 30 days.

I certify that all statements contained herein are true and correct and subject to investigation. I also authorize the release of employment records and other financial information to an agent of ECOFHC for sliding fee determination purposes. If any information is submitted falsely, I understand that my Sliding Fee Discount will be revoked and I will be responsible for the full charges owed.

SIGNATURE: _____ **DATE:** _____

Internal Use Only

Medical Discount (check one): [ ] 100% [ ] 75% [ ] 50% [ ] 25% [ ] Denied: Pay full charges

Dental Discount (check one): [ ] 100% [ ] 75% [ ] 50% [ ] 25% [ ] Denied: Pay full charges

VALID UNTIL: _____ *STAFF SIGNATURE COMPLETING APPLICATION:* _____

Review Date: _____

Revised: 6/20/24