Discounted / Sliding Fee Application – Serve the People Community Health Center

It is the policy of Serve the People Community Health Center (STP CHC) to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. The discount will apply to all services received at this clinic except those services that are purchase from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. If you feel this may be a benefit to you and your family, you will need to complete the Sliding Fee Scale Program application and provide verification of income.

Head of Household information:		
Today's Date:	Date of Birth:	
Last Name:	First Name:	Middle Name:

Complete for all employed adult household members. Proof of income (income tax return or last two paystubs) must be provided to STP CHC. Otherwise, services will be rendered at customary price.

Employed Person	Company Name	Income (Before Taxes)	How often do you get payed? (circle one)	
		$	Weekly	2 times per month
			Monthly	Every 2 weeks
		$	Weekly	2 times per month
			Monthly	Every 2 weeks

Total of all other sources of income (this includes, but it not limited to, alimony, pension, child support, disability, social security, unemployment, etc.)	$

Number of Dependents:	

By signing below, I agree that the STP CHC staff may contact each employer listed and or other agencies to confirm my income. I will provide STP CHC with proof of income for calculating my discount. I will be asked to reapply for the program on an annual basis. I agree to inform STP CHC if there are changes to my income, household size, or insurance coverage. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of services. I hereby certify that the information I provide is correct. I also agree that paying the discounted price for my health services is not a barrier for me. If in anytime this payment becomes a barrier I will notify a staff member immediately.

Applicant's / Patient's Signature:		Date:	
Guardian or Power of Attorney's Signature:		Date:	

For office use only:

Effective date:	
Total Income:	
Sliding Fee:	
Discounted Price:	

Mail completed form and proof of income to Serve the People at 1206 East 17th Street, Suite #101, Santa Ana, CA, 92701