Hilltown Community Health Centers, Inc.

Sliding Fee Discount Application

It is the policy of Hilltown Community Health Centers, Inc. (HCHC), to make available a sliding fee discount program to ensure that no patient will be denied health care services provided by HCHC due to an inability to pay or on the basis of race, color, religion, creed, sex, gender, gender identity or gender expression, age, marital status, national origin, mental or physical disability, political belief or affiliation, veteran status, sexual orientation, genetic information, and any other class of individuals protected from discrimination under state or federal law with respect to the provision of services. Discounts are offered based on family size and annual household income. Please complete the following information to determine if you or members of your family are eligible for a discount.

The Sliding Fee Discount Program will only be made available for medical, dental, optometry and behavioral health clinic visits. Sliding Fee Discounts are not available for Optometry and/or Dental hardware, such as dentures and eye glasses and not for 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.

If you have questions or need assistance completing this form please contact an HCHC Navigators at 413-667-2203 or the Billing Manager at 413-238-4114.

HOUSEHOLD/FAMILY INFORMATION

Family is defined as: a group of two people or more (one of whom is the head of household) related by birth, marriage, or adoption and residing together and any person who is claimed as a dependent for Federal tax purposes; all such people (including related subfamily members) are considered as members of one family.

PATIENT NAME :	
RELATIONSHIP TO HEAD OF HOUSEHOLD:	
HOUSEHOLD MAILING ADDRESS:	
PHONE NUMBER:	

Defined Family Living at Household Address:

Name:	Date of Birth:	Relationship

Annual Household Income:

Income Source:	Self	Other Family Member(s)	Total
Gross Wages, salaries, tips, etc.			
Income from business and self-employment.			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement income.			
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.			
Total			

NOTE: Please attach copies of all documents or self-declaration statements being used to verify income.

I certify that the family size and income information shown above is correct.

Name (Print):

Signature: Date:

Official Use Only

Patient Name:
Approved Discount:
Approved By:
Date Approved:
List of Documents used to verify Income, please attach copy;