tandem health

Sliding Fee Scale Application

(Please Return This Application within 10 Days to Avoid Denial of Application)

Name: ______________________________________ Social Security Number: _____-___-_____

Address: ____

City: ________________________ State: __________ Zip Code: _________________

Telephone No:(______)______-________ Alternate No:(_____)_______-________ DOB: ____________

Monthly Household Income: $________ Family Size: ______ Insurance ☐ Yes ☐ No

Please list all household members, age, and work/school status. ***Be sure to include yourself.***

Name:	**Age:**	**Work/School:**	**Date of Birth:**	**Medicaid Eligible Y/N?:**
1.				
2.				
3.				
4.				
5.				
6.				

The following items must be brought in to determine eligibility:

Income Documentation

(Please Check All That Apply)

- Last two (2) Payroll Check Stubs: ☐ YES ☐ NO
  Date: ____/____/____ Weekly $_______
  Bi-weekly $_______
  Monthly $_______
- Proof of all household income by any other source (child support, etc.): ☐ YES ☐ NO
- Public Assistance Award Letter: (Housing, Food Stamps, etc.) ☐ YES ☐ NO
- SS √ Stub or Benefits Statement: ☐ YES ☐ NO
- Other (Migrant Worker, etc.):__________________

Identification Documentation

(Two items required)

- Social Security Card (see above): ☐ YES ☐ NO
- Birth Certificate: ☐ YES ☐ NO
- Picture ID: ☐ YES ☐ NO
- Voter Registration: ☐ YES ☐ NO
- Visa/Work Permit: ☐ YES ☐ NO
- Passport: ☐ YES ☐ NO
- Other: ☐ YES ☐ NO

***Note: Proof of date of birth required.**

SFHC Medical Record No:_______________________

Regardless of discount determined, a Nominal Fee is required at the time services are rendered.
If you do not provide the appropriate documentation you are responsible for the entire amount of the "BALANCE DUE".
In the event my income changes or I obtain insurance, I will notify Tandem Health immediately.
I authorize Tandem Health to disclose my financial information in the event of a third party audit.
In compliance with Federal laws, I certify that the information I have submitted it TRUE.

Applicant's Signature: ______________________________________ **Date:** _________________

Additional Household Member (Age 18 & Older): ___________________________ **Date:** _________________

Tandem Health Use Only

Approved: ________ **Level:** ________ **Not Approved:** ________ **Review Date:** ________ **Reviewed By:** ________

Date: _____________

Rev. 9/18 HWC