Sliding Fee Application
Oak Orchard Health

300 West Avenue
Brockport, NY 14420

77 S. Main Street
Lyndonville, NY 14098

301 West Avenue
Albion, NY 14411

Because we are a Community Health Center, we have the opportunity to offer a discount on your services based on your annual income. If you feel this may be a benefit to you and your family, you will need to complete this Sliding Fee Program application and provide verification of income.

Head of Household Information:

Name: (First, middle initial, Last):	Home Phone	Cell Phone:	Work Phone
Address	City	State & Zip	County
# of people being supported in the home:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		

Income Information: Please complete for all adult household members who are employed: **PROOF OF INCOME (INCOME TAX RETURN AND LAST FOUR PAYSTUBS) MUST BE PROVIDED TO OAK ORCHARD HEALTH (OOH).** Otherwise, services will be rendered at customary price.

If your income is $0, how are you meeting your food, clothing, shelter and transportation needs?

Employed Person	Company Name	Income (Before Taxes)	Paid how often? (Check One)
		$	☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
		$	☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
Other sources of income:	Alimony $	TANF $	Pension/Retirement $
Child Support $	Disability $	S.S.I. $	Social Security $
Unemployment $	Other $	Other $	Other $

Household Information: List ALL individuals in household, including the head of household.

Name	Date of Birth	Relationship	Age	Income	Employed
1.					**Yes/No**
2.					**Yes/No**
3.					**Yes/No**
4.					**Yes/No**
5.					**Yes/No**
6.					**Yes/No**

By signing below, I agree that the OOH staff may contact each employer listed and or other agencies to confirm my income. I will provide OOH with proof of income for the purpose of calculating my discount. I will be asked to reapply for the program on an annual basis. I agree to inform OOH 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.

Applicant Signature: ______________________________ Date: _____________

Guardian or Power of Attorney Signature: ______________________ Date: _____________

Please return your proof of income with this application page.

For Office use only:

Total Income	
Expire Date	
Co-Pay	
Pharm/Lab/ X-Ray %	

Effective 8-1-2012