KNOX COUNTY COMMUNITY HEALTH CENTER(S)
SLIDING FEES SCALE DISCOUNT APPLICATION

Patient Name_____ Date of Birth_____

Street_____ City_____ State_____

Zip Code_____ Phone _____ Alt Phone number_____

It is the policy of the Knox County Community Health Center (KCCHC) to provide essential medical, mental health, behavioral health, and dental services regardless of the patient's ability to pay. If qualified, a discount may be applied to copayment, co-insurance, and/or deductible balances that are greater than the nominal fee. To qualify for the "sliding fee scale" you must provide proof of household income and the household occupancy. The current nominal fee is $20 for medical services, $10 for mental and behavioral health services, and $20 for dental services.

**Please Note:** Lab fees are deeply discounted and the actual cost of the lab presented to KCCHC is charged to the patient with no mark-up or additional service fees application.

Please provide the following information for **all people in your immediate family who live in your home.** For purposes of assistance, **immediate family** is defined as the patient, the patient's spouse, and all of the patient's children under 18 who live in the patient's home, or that you are **legally responsible for.**

| *Household Members First and last name* | *Relationship* | *Date of Birth* | *Earned** | *Unearned** |
|---|---|---|---|---|
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| | | | | |
| ***TOTAL INCOME**** | | | *$* | *$* |
| ***# of Dependent Children Under Age 18*** | | | | |

***Income includes all earned income/wages and unearned income including wages, salaries, tips, long term disability, self-employment, unemployment, social security, pensions/retirement, and worker's compensation.***

**Total # of children child support is paid on, but not living in home_____**

**Acceptable forms of proof of income (most recent)**: two check/paystubs, tax return or W-2, public assistance of Social Security letter, Child Support, alimony, unemployment, bank statements, Medical Assistance or Dept. of Social Services Certification letter. (**Include ALL income**)

**Documentation of No Income:** If you report $0 income, please explain how daily needs are being met.

_____

_____

By my signature below I attest that **I have an annual income of $0.**

Patients Signature_____ KCCHC Witness_____

***By reporting that have $0 income, you will automatically be referred to our Patient Care Coordinator. ***

Created 04/2024

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**SLIDING FEE DISCOUNT AGREEMENT:** I understand and agree that some services rendered are based on my ability to pay. If payment for other services is determined by and based on a sliding fee scale, I understand I am responsible for my share of the cost of services rendered at time of service and that failure to provide "proof of income" will result in me being charged 100% of the cost of services received and/or provided.

I understand that I must update this information if my situation changes and that a new Discount Application must be completed at least every twelve (12) months. If an unpaid balance exists on my account after applying my Discount percentage, I agree to make payment arrangements and honor the terms. I understand that if I am unable to make a payment in any given month; I must contact the Billing Office prior to the due date to discuss my need to modify my payment arrangement.

Certification: I certify that the family size and income information shown above is correct. **I understand that documentation supporting my financial position is required before my discount can be approved and that I must provide this information within 30 days or prior to my next visit if sooner.**

| _____ | _____ | _____ |
|---|---|---|
| Patient Name (print) | Signature of Patient or Guarantor | Date of signature |

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