IMPERIAL VALLEY Family Care Medical Group
OUR FAMILY CARING FOR YOUR FAMILY
RURAL HEALTH CLINIC
608 G Street Suite 1A Brawley, CA 92227
760-351-1011

SLIDING FEE SCALE APPLICATION

1. Eligibility for the Rural Health Clinic Sliding Fee Scale is dependent on the number of people in your family, your assets, and your family income.
2. Please fill out the Sliding Fee Scale application. Sign and date the application and return it with proof of income to the RHC office.
3. **PROOF OF INCOME** – We need current paycheck stubs or a letter from the company/person that you work for that reflects one month's income for ALL applicable household members. If you or any applicable household member receives any other source of income, please provide that information as well.
4. **These are some examples of other income that you need to prove:**

   √ Copy of most recent federal income tax forms.
   √ Social Security, VA Benefits
   √ Pensions, Retirement
   √ Public Assistance
   √ Unemployment
   √ Disability Income, Worker's Compensation
   √ Child Support, Alimony
5. **We need proof of any assets you may own. These are examples of assets:**

   √ Bank Accounts-Savings and Checking
   √ Stocks, Mutual Funds, Bonds
   √ Land or House that you do NOT live in
   √ Certificates of Deposits
   √ Trust Funds
6. All Co-Payments are required at the time of your office visit.
7. All applicants MUST REQUALIFY annually.
8. The Sliding Fee Scale will be reviewed and modified in accordance with the institution's fiscal accounting year.
9. Records of all qualified applicants will be maintained in the RHC Office.

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Sliding Fee Scale Application

Today's Date: / /

Patient Information

First Name:	Middle Initial:	Last:	Other Name:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /	Social Security # - -	Do you have insurance? (circle one) Yes No		
Marital Status: (circle one)	Single In a relationship Married Divorced Separated Widowed			

Household Size

Name	Date of Birth	Social Security Number
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

Household Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Sliding Fee Scale:

A – 80% Discount

B – 60% Discount

C – 40% Discount

D – 20% Discount

E – 0%Discount

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I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment.
I further agree to inform MD COMMUNITY CARE CENTER if there is a significant change in my income; otherwise it will be updated annually.
If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of MD COMMUNITY CARE CENTER.
I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____

Name (Print):_____

Signature: _____