ADAMS COUNTY HEALTH DEPARTMENT
PROMOTION PROTECTION PREVENTION
330 Vermont • Quincy, Illinois 62301 • Phone 217-222-8440 • Fax 217-222-8508

# Sliding Scale Discount Application Form

**This program is designed to provide discounted care to those who have no means, or limited means to pay for their medical services (uninsured or underinsured). ACHD will offer a sliding fee discount program to all who meet the eligibility criteria of the program. ACHD bases the program on the Federal Poverty Guidelines.**

**For eligibility consideration, the application form and proof of income must be submitted within 7 days of the service date and annually thereafter (or earlier if income changes). Proof of income will be reviewed for authenticity and accuracy. Falsifying documents may be subject to legal penalty. Patient will be charged full fees until this is complete.**

**Date: _____**

**Head of Household Name: _____ DOB: _____**

**Address: _____ City: _____ State: _____ Zip: _____**

**Home Phone: _____ Cell Phone: _____**

**Household Size – Number of immediate family (spouse, life partner, children under 21) that are dependent on family income: _____**

| Household Member Names | DOB | Type of Insurance |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Gross Annual Income**

| Source | Self | Spouse | Other | Total |
|---|---|---|---|---|
| Gross Wages, salaries, tips | | | | |
| Social Security, pension, annuity, veterans' benefits | | | | |
| Alimony, child support, military family allotments | | | | |
| Income from business, self-employment | | | | |
| Unemployment, workers compensations | | | | |
| **TOTAL Household Income** | | | | |

**I certify that the information shown above is true and correct to the best of my knowledge. I agree to notify the health department if there are any changes in my household income, size or if I receive health insurance benefits including Medicare or Medicaid. Failure to report any changes may result in dismissal from the Sliding Fee Discount Program and my account will be adjusted as such. I agree to pay any outstanding balances and understand that payment plans are available to me.**

_____ _____

**NAME (PRINT)** **SIGNATURE/DATE** **03/2022**

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## FOR STAFF USE ONLY

**The patient has provided the following proof of income (check all that apply):**

- ☐ **Income Tax Statement – 1040**
- ☐ **Current Paystubs (at least 2 previous paystubs in the last 30 days)**
- ☐ **Letter of Employment – patients with new employment that do not have 2 paystubs, must include rate of pay and hours scheduled to work**
- ☐ **Self-Employment – three most recent months of business income and expenses**
- ☐ **Workers Compensation Income – benefit check, stub, or award letter**
- ☐ **Unemployment Compensation – award letter**
- ☐ **Social Security Payments – award letter**
- ☐ **Retirement Income – explanation of benefits**
- ☐ **Child Support or Alimony Income – Court Documents**
- ☐ **Military or Veteran Income – award letter**

**Sliding Fee Scale:** **YES** **NO**

**Effective Date: _____ Expiration Date: _____**

**Approved BY: _____ Date:_____**

**This form must be scanned into patient electronic record.** **03/22/2022**