



## Sliding Fee Application and Certification Effective February 2008 through March 2009

North Shore Community Health, Inc. offers an adjusted fee for certain medical and dental services provided in our health centers. Eligibility is determined by a method that considers your family size and income. NSCH, Inc. will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap or political beliefs.

Name: \_\_\_\_\_

Account: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Do you have health insurance?      Yes    No

Do you have dental insurance?      Yes    No

Please circle one

Medicaid    Medicare    Commonwealth Care

Other: \_\_\_\_\_

Family Size and Income per Family Member							
Name	Relation	Date of Birth	Income	Per*	Source**	Special Notes/Adjust	Total Annual
<b>Total:</b>							

\*Per      Weekly    Biweekly    Semi Monthly    Monthly    Annually

\*\*Source    Wages, Salary, & or Tips      Unemployment Benefits      Welfare    Benefits/food stamps      Child Support

Social Security                      Trust Funds/Loans                      Rent                      Interest                      Other

I certify that these statements are true and correct. I authorize NSCH, Inc. to verify my income stated above.

Applicant's Signature: \_\_\_\_\_ Employee Review: \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_