Patient Name: _____
DOB:_____
MRN:_____
Date:_____

Sliding Fee Notice and Application

The Sliding Fee Discount Program is designed to provide discounted care to those with no means or limited means to pay for services (uninsured, underinsured, out of network.)

Completing this form is necessary to apply for Connect Medical Clinic's Sliding Fee Discount Program.

The information provided on this form is confidential and will be used solely to determine eligibility for the Sliding Fee Discount Program. It will not be used for census or other unrelated reporting purposes and will be maintained as part of your medical record.

Patients will not be discriminated against based on age, gender, race, creed, disability, national origin or insurance status. **Dignity, confidentiality, and respect will be given to all who seek and/or are provided charitable services.**

Sliding Fee Discounts will be based on self-declared household size and total household income. Connect Medical Clinic recognizes families do not always fit the traditional model. Connect identifies the definitions of a **Household and Income** as below:

> *A. **Household** consists of all the persons who occupy a house or apartment, or a unit of individuals for whom you bear responsibility or with whom you share a living space.*

> *B. **Income** includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.*

Income will be verified by providing Connect staff with a month's pay stubs or last year's tax return or W2 before services are received. *Self-reported income may be accepted on a case-by-case basis, and services may be provided with the expectation that necessary documentation will be submitted within two weeks. If documentation is not provided within this timeframe, services will be billed at 100%.*

Patient Name: _____
DOB:_____
MRN:_____
Date:_____

Sliding Fee Notice and Application

Eligibility will be determined based on the information and documentation submitted. Applicants will be notified of their eligibility and applicable discount level. If additional documentation is required, Connect Medical Clinic staff will contact you with further instructions.

The Sliding Fee Discount applies only to eligible services provided at Connect Medical Clinic. Services, tests, procedures performed outside of Connect Medical Clinic are not eligible for the Sliding Fee Discount Program. **Laboratory services that are processed outside our facility are not eligible for the Sliding Fee Discount.**

An approved Sliding Fee Discount Program covers patient balances incurred within 12 months after the approved application date. A denied applicant can reapply after the 12 months have expired or when there has been a significant change in household size or income.

This form must be completed every 12 months or if your financial situation changes.

FORM: I hereby submit to Connect Medical Clinic my unverified income information to be used to determine my eligibility for the Sliding Fee Discount.

Number living in Household (including you): _____

Reported monthly Household Income:_____ / month or _____ year

I certify that the household size and income is correct to the best of my knowledge.

Patient signature: _____ Date: _____

Print Patient Name: _____

Internal Clinic Use Only

Date income verification received: _____

Sliding Scale determination: _____

Staff Signature:_____ Date:_____

Reviewed 09.20.2026