CommuniCare+OLE

Caring for Napa, Solano & Yolo Counties

SLIDING FEE SCALE APPLICATION (ENGLISH/SPANISH)

Place Patient/Client Label Here

You may be eligible for our Sliding Fee Scale Program. To apply, complete the information and sing below. All information for this voluntary program is confidential.

Please list all dependents living in your household (include yourself/spouse, children, and any dependent relatives):

				Internal Use Only	
Name	Relationship	Date of Birth	Income	Frequency Paid Check how often patient is paid	Total Monthly Income
1. (Self)	(Self)			☐Weekly x 4.330 ☐2x month x 2.00 ☐Biweekly x 2.167 ☐Monthly x 1.0 ☐Annually x 0.08333	
2.				☐Weekly x 4.330 ☐2x month x 2.00 ☐Biweekly x 2.167 ☐Monthly x 1.0 ☐ Annually x 0.08333	
3.				☐Weekly x 4.330 ☐2x month x 2.00 ☐Biweekly x 2.167 ☐Monthly x 1.0 ☐ Annually x 0.08333	
4.				☐Weekly x 4.330 ☐2x month x 2.00 ☐Biweekly x 2.167 ☐Monthly x 1.0 ☐ Annually x 0.08333	
5.				☐Weekly x 4.330 ☐2x month x 2.00 ☐Biweekly x 2.167 ☐Monthly x 1.0 ☐ Annually x 0.08333	
				Total Gross Monthly Income for Household	
				Total Household Size	

Important: ATTACH PROOF OF INCOME TO THIS FORM

I know that giving false information will mean that I won't get discounts. I also know that I will have to pay for the full fee and will not be eligible for the Sliding Fee Program. I know that just because I apply for a discount doesn't mean that I will get a discount. I also know that if I don't tell CCOLE about any changes to how much money I make or the amount of people in the house, CCOLE may immediately take away any discounts.

By signing this form, I understand that self-reported income is only valid for 30 days from the signature date below (one time per year) and unless proof of income is provided, I will be responsible for the full cost of the services provided after that date.**

_______________________________ _______________________

Applicant/Guardian Signature **Date**

**If patient is unable to provide proof of income, see Self-Attestation on next page.

STAFF USE ONLY – Scan completed application into patient's chart

Staff Name: ____________________

Application Date: ____/____/______ Expiration Date: ____/____/______

Patient qualifies for SFS discount (circle): Yes No If "Yes" qualifies for SFS category (circle): A B C D E F G