CommuniCare+OLE
Caring for Napa, Solano & Yolo Counties

SLIDING FEE SCALE APPLICATION (ENGLISH)

Place Patient/Client Label Here

You may be eligible for our Sliding Fee Scale Program. To apply, complete the information and sign 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):

Name	Relationship	Date of Birth	Income	Frequency Paid Check how often patient is paid		Total Monthly Income
				Staff Use Only		
1. (Self)	(Self)			☐ Weekly x 4.330 ☐ Biweekly x 2.167	☐ 2x month x 2.00 ☐ Monthly x 1.0 ☐ Annually x 0.08333	
2.				☐ Weekly x 4.330 ☐ Biweekly x 2.167	☐ 2x month x 2.00 ☐ Monthly x 1.0 ☐ Annually x 0.08333	
3.				☐ Weekly x 4.330 ☐ Biweekly x 2.167	☐ 2x month x 2.00 ☐ Monthly x 1.0 ☐ Annually x 0.08333	
4.				☐ Weekly x 4.330 ☐ Biweekly x 2.167	☐ 2x month x 2.00 ☐ Monthly x 1.0 ☐ Annually x 0.08333	
5.				☐ Weekly x 4.330 ☐ Biweekly x 2.167	☐ 2x month x 2.00 ☐ 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.** Sliding fee documents are valid for 1 year from signature.

_____   _____
Applicant/Guardian Signature   **Date**

**If a 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