



**AZALEA HEALTH  
SLIDING FEE APPLICATION**

Azalea Health is a non-profit organization that receives a defined amount of Federal funding to supplement the cost of providing Medical/Dental care to patients who are eligible to participate in the sliding fee scale program. Eligible patients will also qualify for reduced cost prescriptions. To determine your eligibility for this federally funded program, verification of your income is required. ***You must update this information at least annually to continue your participation in the program. This information is only used to calculate your discount and is kept confidential.***

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

**I would like to apply for the Azalea Health Sliding Fee:** Yes No

Household Size: # of Adults \_\_\_\_\_ # of Children \_\_\_\_\_ Total \_\_\_\_\_

*A household constitutes any group of individuals, with or without children, living under the same roof that pool resources for monthly expenses. Persons may or may not be related. Please List below.*

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

**Documentation Required for Sliding Fee:**

- a. Pay Stubs (Household's pay stubs for most recent 4 weeks)
- b. Employer Letter (If paid in Cash)
- c. Unemployment Benefit Summary Letter
- d. Copy of Tax Records, Bank Statements
- e. Other (Veterans, Social Security, Pension Benefits, Child/Alimony, Workman's Comp)
- f. No Income - Provide a Notarized letter from person you know (not related) verifying you have no income and stating your living arrangements (food/shelter)
- g. Proof of Residency (utility bill, lease/mortgage, legal correspondence mailed to you in your name or your spouse's name)
- h. Proof of Identity (Government Issue ID, Current DL, School ID, Birth Certificate)

I certify that my total Household income is \$ \_\_\_\_\_/monthly or \$ \_\_\_\_\_/yearly

By signing this, I certify that all of the information is true. I understand that misrepresentation of income in order to participate in the sliding fee scale program is Federal Fraud. I understand that I am responsible for reporting if the number in my household or my income changes; I agree to report those changes to Azalea Health at the time of my next office visit. I understand and agree that I am responsible for payment of my portion of the charges after the sliding fee scale is applied.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Office Use Only:**

- Pay Stub  Copy of Taxes  Notarized Letter  Proof of Residency  Employer Letter
- Medicaid Eligibility Letter  Other (Social Security/Pension  Unemployment Benefit Letter
- Other Notarized Letters  Child/Alimony  Workman's Comp  Other Income  Bank Statements

Effective Date \_\_\_\_\_ Renewal Date \_\_\_\_\_ Approved by \_\_\_\_\_ Date \_\_\_\_\_



### Room and Board Confirmation

*(This information needs to be provided by the person with whom you are living.)*

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

To Whom It May Concern: **Azalea Health Intake**

This is to confirm that \_\_\_\_\_ is living at my house/apartment.

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

He/She currently pays me: \$\_\_\_\_\_ per \_\_\_\_\_.

**OR**

This is to confirm that \_\_\_\_\_ is living at my house/apartment and is unable to pay rent at this time as he/she does not have any income.

It is my understanding that I must notify Azalea Health of any changes. By signing this, I understand that a misrepresentation of the information that I provide to Azalea Health is Federal Fraud.

Thank you,

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Notary Stamp: \_\_\_\_\_ Date: \_\_\_\_\_  
(Notary Print Name)

\_\_\_\_\_  
Signature



## Employment Letter

*(This information needs to be completed and signed by your employer, not by you.)*

I, \_\_\_\_\_, authorize my Employer to provide Azalea Health with the employment information requested below.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date of Hire: \_\_\_\_\_ Hourly/Salary: \_\_\_\_\_ Hours Worked: \_\_\_\_\_

Pay Period (circle one) Weekly, Bi-Weekly-or every 2 wks, Semi-Monthly-or twice per month, Monthly

Gross income for previous month: \_\_\_\_\_ Amount \$ \_\_\_\_\_

\_\_\_\_\_  
Employer Print Name

\_\_\_\_\_  
Signature

Employer Telephone: \_\_\_\_\_



## No Income Verification

*(This information needs to be provided by a person, **not related to you**, who knows you and will verify your living arrangements.)*

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

To Whom It May Concern: **Azalea Health Intake**

This is to confirm that \_\_\_\_\_ is personally known to me for \_\_\_\_\_ years. To my personal knowledge, \_\_\_\_\_  
Is living at:

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

I certify that \_\_\_\_\_ is not working and has no means of income at this time.

By signing this, I understand that misrepresentation of the information that I provide to Azalea Health is a Federal Fraud.

Thank you,

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Notary Stamp: \_\_\_\_\_ Date: \_\_\_\_\_  
(Notary Print Name)

\_\_\_\_\_  
Signature