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 recourses 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