MISSOURI HIGHLANDS HEALTH CARE
SLIDING FEE APPLICATION

The Sliding Fee Scale is a method for providing reduced fees, based on a household's size and income. In order to be eligible for this program, the following application must be completed and submitted with the following information for all persons in the household:

- Most recent Income Tax Return OR
- Current income documentation (see Policy & Procedure for examples)

Head of Household: Last _____ First_____ MI____ Phone:_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

SOURCES OF INCOME: Income information required for all household members. Household is considered all persons living with you at the same address.

Source	Amount	Weekly	Bi-weekly	Twice per month	Monthly	Annually
Salaries and Wages (Self)	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Salaries and Wages (Spouse	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Salaries and Wages (Other)	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Pension/IRA/Keogh Plan	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Workers Compensation	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Social Security (Self/Spouse)	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Social Security (Children)	_____	[ ]	[ ]	[ ]	[ ]	[ ]
SSI	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Child Support/Alimony	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Interest Income	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Military/Veterans Benefits	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Unemployment Benefits	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Public Assistance	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Other Family Members	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Other Income (specify)	_____	[ ]	[ ]	[ ]	[ ]	[ ]

HOUSEHOLD SIZE: List all household members by Name, Birthdate, and Social Security Number, **including yourself**

NAME	BIRTHDATE	SOCIAL SECURITY #

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY BEFORE SIGNING

I, the undersigned, have completed this application for Sliding Fee eligibility and confirm that this information is true and accurate, to the best of my knowledge. I further understand that any change in my financial and/or household status must be reported immediately to Missouri Highlands Health Care and a new application must be submitted. I understand that this application expires at the date determined by MHHC below and that I have to reapply at such time with all required documentation. I understand any falsifications or the failure to report changes may result in my being made ineligible for the Sliding Fee adjustments made available by MHHC. I understand if found that fraud has occurred due to misreporting of income and/or household size in order to obtain Sliding Fee discounts, that the discounts will be reversed and I will be responsible for 100% of the charges and will be ineligible for any Sliding Fee discounts in the future.

Applicant's Signature: _____ Date: _____

Prepared by: (MHHC staff): _____Date: _____

_____ Approved _____Slide Level Approved Expiration Date: _____

Provisions, if any: _____

_____ Denied Reason: _____

_____ Pending Reason:_____

Certified by: (MHHC Staff) _____ Date:_____

Rev. 5/17/2010

Missouri Highland Health Care
Sliding Fee Documentation Requirements

Income & Household Members:

1. **Completed Sliding Fee Application**
   (including birthdays and social security numbers for all people living in the home)
2. **Most recent Income Tax Return for ALL adults living in the home.**

   OR
3. **Current income documentation for ALL adults living in the home.**
   (which may include one or more of the following):
   - Two most recent paycheck stubs for each working member of the household
   - Other income verification provided by employer such as a statement of earnings for a period of at least two pay periods
   - Unemployment check stub(s) or determination forms
   - Social Security and/or Supplemental Security Income annual award statement
   - Workers' Compensation award letter or check copies
   - Child Support/ Alimony statement
   - Interest Income statement
   - Veterans Benefits check copies or annual benefit statement
   - Public Assistance monies
   - Letter from Division of Family Support verifying household income amount and household members
   - Railroad retirement award letter
   - Retirement/pension award notice
   - Self-Employed individuals need to provide current income statement and most recent Income Tax Return with all schedules
   - If a house hold member is attending college with a Pell Grant, then provide the award letter

*If any adult member in the home is not working, provide a signed and dated statement from them stating why they are not working.

If you have any questions or need assistance, please feel free to contact our office.

MISSOURI Highlands HEALTH CARE

Sliding Fee Application

Patient's Self- Declaration Regarding Non-Filing of Income Tax Returns

I, the undersigned, state that neither I nor any of my household members have filed an Income Tax Return with the Federal Government and/or State of Missouri within the past year. I confirm this information is true and accurate to the best of my knowledge. Further, I understand that any falsification or failure to report information on my part will result in my Sliding Fee discounts being reverse and I will pay 100% of all charges from the date of this application forward.

Applicant's Signature: _____Date: _____

Witness (MHHC Representative): _____ Date: _____

*If applicable, please sign below. **If not applicable,** write NA in the Signature line.

I, _____ state that I am currently not working.

Applicant's Signature: _____ Date: _____

Witness (MHHC Representative): _____ Date: _____

*This form is required for **EACH** adult applying for Sliding Fee Application.