Cross Trails Medical Center

Sliding Fee Option Form / Application

Section A

The Sliding Fee Scale is a method for providing reduced fees based on a household's size and income. Some may qualify to help with deductibles, non-covered services, etc. even if there is an insurance.

Please check the appropriate option and sign below:

☐ I would like to apply for the Sliding Fee. Complete Section B of this form and return to the receptionist.

☐ I do not wish to apply for the Sliding Fee at this time. I realize that I can apply for the Sliding Fee at any time.

_____

Signature of patient, parent, guardian, or executor

A copy of this form will be used for each member in the household unless otherwise requested.

Section B

In order to be eligible for this program, the following application must be completed and returned to Cross Trails Medical Center. Proof of income (two most current pay stubs for all members of the household, last year's income tax return, and proof of all other income received by members of the household).

Head of Household Information:

Last _____ First _____ M.I. _____

Mailing Address: _____ City _____ State _____

Current Home Phone # or Contact Phone(s) #: _____

1 What is your annual GROSS INCOME (all income sources)? See attached

2 How many people, including yourself, are in your household? _____

3 List NAMES and AGES of those people included in question #3:

Name	Age	Name	Age

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY!

I, the undersigned, have completed this application for Sliding Fee eligibility and confirm that this information is true and correct, to the best of my knowledge. I further understand that any change in financial status or the number of people in my household must be reported immediately to Cross Trails Medical Center and a new application must be completed. I understand that, upon request of Cross Trails Medical Center, there will be a review of my application with the possibility of discount/eligibility changes. I understand that any falsifications or the failure to report any changes may result in becoming ineligible for the Sliding Fee adjustments made available by Cross Trails Medical Center.

Applicant's Signature: _____ Date: _____

Section C

Office Use Only:

☐ Approved

☐ Rejected

Discount %: _____

Reason for rejection: _____

Approved/Rejected by: _____ Date: _____