

**Chiricahua Community Health Centers, Inc.**

**Sliding Fee Application**

Arizona State Primary Care Program (ASPCP)       Federal Program (Fed)

**A. Client/Patient's Information:**

Last Name	First Name	Middle Name	Date of Birth
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**B. Household Size: *Include all members in your family (reference "Household" definition is necessary)***

Full Name	√*	Gender	Birth Date	Social Sec #	Relationship to Client	Marital Status
<i>(Head of Household)</i>		M F				
		M F				
		M F				
		M F				
		M F				
		M F				
		M F				

(\* a checkmark indicates if the household member is sliding fee eligible)

**C. Initial Visit** *(applies to entire family)* - **I have received information identifying the documents necessary for my financial screening.** I understand that I must return to the clinic with the missing documents as soon as possible, this eligibility expires in  45-days (ASPCP) on: \_\_\_\_\_ **OR**  One-day (Fed SFS) on: \_\_\_\_\_

Family Income: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CCHCI Notes:

Presumptive eligibility approved / Missing documents:

**D. Proof of Arizona Residency (required for ASPCP – Indicate the type of proof attached)**

<b>REQUIRED</b>	<input type="checkbox"/> Arizona Driver's License or Photo ID Card
<b>PLUS one of these:</b>	<input type="checkbox"/> Recent <b>Utility Bill</b> or U.S. Post office record showing an Arizona address
	<input type="checkbox"/> <b>Letter</b> from a non-relative landlord/neighbor stating the client's Arizona address
	<input type="checkbox"/> <b>Rent, Mortgage, or lease receipt</b> , in the <b><i>client's name</i></b> , with an Arizona address

**E. Client/Household income (indicate the verification method used and attach support documentation for file)**

Paychecks or pay stubs *(current 4-week's income)*

Unearned income *(retirement benefits, Social Security, SSI, child support)*

Letter of Income verification form employer *(should be on employer letterhead and signed)*

Income Tax Return *(use Total Income line or other tax forms (W-2) for most recent year)*

Client self-declaration  Other Indicate (Odd Job List, In-kind, etc.)

**F. Insurance declaration**

**Does the patient currently have insurance?**  Yes  No (if Yes, state insurance/Medicare information)

Insurance Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insured Name \_\_\_\_\_

**G. Reason for Federal Eligibility (skip this if ASPCP)  Dental Eligibility Only**

<input type="checkbox"/> Not an Arizona Resident	<input type="checkbox"/> Incomplete documentation
<input type="checkbox"/> Medicare / Insurance – under insured	<input type="checkbox"/> Has AHCCCS and is qualified for Federal SFS for Dental coverage. (adults non-emergency care)

**H. Verification of Household Size (for each dependant)**

<input type="checkbox"/> Birth Certificate	<b>AND</b>	<input type="checkbox"/> Social Security Card <i>(If applicable)</i>
<input type="checkbox"/> Passport		

Client/Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

**I. AHCCCS Application/Status**

A  
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C  
C  
S

<input type="checkbox"/> <b>AHCCCS Application made and Pending</b>	<input type="checkbox"/> <b>Approved</b> (Move to Federal Section for Dental) (Date)
<input type="checkbox"/> <b>AHCCCS Application made</b> and Patient determined <b>not Eligible</b> (per Health-e-App) <b>Continue with ANNUAL Eligibility Section</b>	<input type="checkbox"/> <b>Denied</b> (must have denial for each Household member who will receive sliding fee services) <b>Continue with ANNUAL eligibility Section</b>
<input type="checkbox"/> <b>AHCCCS Ineligible</b> (as determined by migrant status or _____. Client/Patient has signed the AHCCCS INELIGIBLE Form) <b>Continue with ANNUAL Eligibility Section</b>	

I certify that the above is correct and I currently have no insurance. I also understand that this eligibility for sliding scale services is only for 45 days, and expires on : \_\_\_\_\_ (date) (not necessary if in-eligible for AHCCCS)

Signed: \_\_\_\_\_ Date \_\_\_\_\_

**Annual Sliding Fee Scale Eligibility Determination**

**ASPCP**     **Fed SFS**

**J. Determination of Federal Poverty Level & Sliding Fee Scale Payment**

A  
N  
N  
U  
A  
L

Household Size		<b>Income</b>	\$
Percent of Federal Poverty Level	%	Eligibility Date	
Monthly Prescription Allowable	\$20.00	Expiration Date	
Client's Sliding Fee Scale Responsibility (Percent or Co-pay)	<b>Medical Services:</b> \$20.00 Adult * \$15.00 Child * <b>OR</b>	<b>Dental Services:</b>	
	%	%	

\*change effective 05/01/08

CCHCI Notes:

I affirm that the information I have provided to Chiricahua Community Health Centers, Inc. (CCHCI) is accurate and true to the best of my knowledge. I understand the following:

- ✓ that if I have willfully falsified this application, I may be disqualified from the program
- ✓ there is a \$25 fee for any appointment not kept and not canceled without 24-hour advance notice.
- ✓ that this program covers primary care services ONLY and ONLY those services ordered by a CCHCI provider.
- ✓ if this information changes, I must re-apply with the current information.
- ✓ my payment responsibilities as listed above in section "J".
- ✓ my eligibility date
- ✓ it is my responsibility to re-determine my eligibility before the above expiration date.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Chiricahua Community Health Centers, Inc. Representative \_\_\_\_\_ Date \_\_\_\_\_

<b>Mobile Medical Unit</b> 1100 'F' Avenue Douglas, AZ 85607 <b>Phone: (520) 364-4984</b> (from Willcox call: 384-6300) FAX: (520) 805-1292	<b>Bisbee</b> 108 Arizona Street Bisbee, AZ 85610 <b>Phone: (520) 432-3309</b> FAX: (520)432-3717	<b>Ginger Ryan Clinic</b> 1100 'F' Avenue Douglas, AZ 85607 <b>Phone: (520) 364-3285</b> (from Willcox call: 384-6300) FAX: (520)364-3378	<b>Cliff Whetten Clinic</b> 10566 Highway 191, P.O. Box 263, Elfrida, AZ 85610 <b>Phone: (520) 642-2222</b> (from Willcox call: 384-6363) FAX: (520) 642-3591
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