CLINICAS
DEL CAMINO REAL, INCORPORATED

Application for Sliding Fee

Applicant's Last Name	First Name	Middle Initial	Employer
How many people are supported by this income?			

Please list everyone living in the same household and who share income, food and/or rent. That number includes you, your spouse, and/or any dependents.

	Last Name	First Name	Middle Initial	Birthdate	Age	Relationship to applicant	Income (Weekly/Monthly/Yearly)	Medical Record Number
1								
2								
3								
4								
5								

Total Monthly Gross Income: ____________________

If proof of income is not received and the sliding fee application is not completed within 30 days of service, the patient must pay the full charge. The application qualifies the individuals listed above for the slide category determined for the next twelve (12) months based on the date the application is completed.

Pharmacy Discounts: Please note that the 30 day period to submit proof of income is not applicable for pharmacy discounts. You may be eligible for Clinicas' pharmacy assistance program. However, in order to be eligible for pharmacy discounts through Clinicas' pharmacy program, proof of income must be provided before a prescription is dispensed or you will have to pay the full amount.

I have read and understand all of the information. All information recorded is correct, truthful and complete. If there is a change in the number of applicants or my financial situation, I will contact the health center immediately and re-apply if necessary.

Applicant's Signature: ____ **Date**: ____________________

For Office Use Only:

	Proof of Income Documents	Date Received	Staff Initials
	Most recent Income Tax Return for confirmation of Adjusted Gross Income		
	Copy of most current W-2 (if income tax return has not been filed)		
	Copy of paycheck stubs (for all incomes for a minimum of 1 month)		
	Self-Employment (must provide accounting of income or quarterly tax payments)		
	A letter from family and non-family members confirming that the patient has no income. The letter should include printed name, signature, and date		
	Employer letter (if paid in cash or check stubs unavailable)		
	Social Security award letter or Bank statement showing direct deposit		
	Unemployment benefits report		
	Other (please explain):		

Family Size:	Total Household Gross Income: $____________	Slide Category: ☐B ☐C ☐D ☐E ☐F	Completed by (print name):	Date:	Expiration Date:

CLINICAS
Del Camino Real, Incorporated

Solicitud Para La Escala de Descuentos

Apellido del Solicitante	Nombre	SegundoNombre	Empleador
Cuantas personal se mantienen de estos ingresos?			

Por favor de enlistar a todas las personas que viven en el mismo hogar que comparten los gastos del hogar, comida y/o renta. Ese número debe incluir a usted, su esposo(a), y cualquier dependiente.

	Apellido	Nombre	Segundo Nombre	Fecha de Nacimiento	Edad	Relación al solicitante	Ingresos (semanal, mensual, anual)	MR Number Solo para uso de la oficina:
1								
2								
3								
4								
5								

Ingreso Mensual Total: ____________________

Si el comprobante de sus ingresos no es recibido y la solicitud no es completada dentro de 30 días del primer día de servicio, el paciente debe pagar el costo a precio normal. La solicitud califica a todos los individuos enlistados arriba para la escala de descuentos por los próximos doce (12) meses basado en la fecha en que sea finalizada la solicitud.

Descuentos Para la Farmacia:

Por favor tome en cuenta que el periodo de los 30 días para entregar los comprobantes de ingresos no aplica para los descuentos de farmacia. Usted puede calificar para los descuentos de la farmacia de Clínicas, pero para poder calificar para este descuento en el programa de descuentos de farmacia de Clinicas, **el comprobante de ingresos tiene que proveerse antes de que se le entregue la medicina recetada o tendrá que pagar el costo total. No hay devoluciones por medicina recetada.**

He leído y entiendo toda la información. Toda la información en la solicitud es correcta, verdadera, y completa. Si hay algún cambio en el tamaño de la familia o finanzas, tengo como obligación contactar la clínica y aplicar de nuevo si es necesario.

Firma del Solicitante: ____ **Fecha:** ____________________

Solo Para Uso de la Oficina:

	Proof of Income Documents	Date Received	Staff Initials
	Most recent Income Tax Return for confirmation of Adjusted Gross Income		
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	Copy of paycheck stubs (for all incomes for a minimum of 1 month)		
	Self-Employment (must provide accounting of income or quarterly tax payments)		
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	Employer letter (if paid in cash or check stubs unavailable)		
	Social Security award letter or Bank statement showing direct deposit		
	Unemployment benefits report		
	Other (please explain):		

Family Size:	Total Household Gross Income: $ __________	Slide Category: ☐B ☐C ☐D ☐E ☐F	Completed by (print name):	Date:	Expiration Date:

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