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
- 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: _____

Witnessed by (MHHC representative): _____

_____ Approved _____% of Discount Approved Expiration Date: _____

Provisions, if any: _____

_____ Denied Reason: _____

_____ Pending Reason:_____

Certified by: _____ Date:_____

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