Family Health Services	**Title:** Sliding Fee Discount Program Application PHONE: 419-502-2800 • FAX: 419-502-2821 Valid from March 20, 2025, through March 19, 2026	ID #: FD1006 Effective: 12/17/2025 Page: 1

Family Health Services (FHS) provides services regardless of the patient's ability to pay. Discounts are offered based on total household income and the number of people living in the household. A sliding fee schedule is used to calculate the basic discount and is updated each using federal poverty guidelines.

A fully completed application, including verification of income, must be submitted to the business office for review within 30 days following your appointment. Once the business office reviews the application, it will be determined if a discount can be applied. The business office will notify the patient of their application status once the review process is complete.

☐ **I decline to apply for the Sliding Fee Discount Program. (Please complete the patient's name below and sign and date this form)**

PATIENT LAST NAME:	PATIENT FIRST NAME:	MI:
DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP:
CELL PHONE:	HOME PHONE:	

Are you a college student under the age of 23 living at home with your parents?	YES	NO

List additional household members below. Any person 18 years or older living in the household will need to provide proof of income with this application. Attach an additional page if more space is needed.

1. NAME/ RELATIONSHIP/ AGE:	MONTHLY GROSS INCOME:
2. NAME/ RELATIONSHIP/ AGE:	MONTHLY GROSS INCOME:
3. NAME/ RELATIONSHIP/ AGE:	MONTHLY GROSS INCOME:
4. NAME/ RELATIONSHIP/ AGE:	MONTHLY GROSS INCOME:
5. NAME/ RELATIONSHIP/ AGE:	MONTHLY GROSS INCOME:
6. NAME/ RELATIONSHIP/ AGE:	MONTHLY GROSS INCOME:

You must provide proof of income to be approved for this program. Nominal fee of $20 for each medical, dental and behavioral health visit. Income verification may include pay stubs, W2's, 1099's, most recent tax returns, tax transcript, public assistance, self-attestation.

I understand that all the information given will be confirmed by Family Health Services. I also understand that providing false information will result in an automatic denial of the Sliding Fee Scale Program Application and I will be responsible for the charges incurred during the services rendered.

PATIENT SIGNATURE:	DATE:
PRINTED NAME:	

OFFICE USE ONLY:

Is proof of income attached for each household member over 18?				YES	NO
Slide Level Assigned:	I (Nominal Fee)	II	III	IV	V - Discount not available
Staff Signature:				Date:	