Housing and Income Information

Sliding Fee Discount Program

opendoor Community Health Centers

Why we ask for this information

Open Door Community Health Centers receive grants and federal funding to support our services. Each year we must collect information about the communities we serve to share with our funders. By completing this form, you are helping us keep our funding so we can offer more services.

We combine your information with others and report it in summary form. We do not share any personal information or report data that could be used to identify you.

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1. Information about you and where you live

Name	**Birth date**	**MRN** *Office Use*

Are you a veteran? (Check one) ☐ Yes ☐ No

How do you describe where you live? (Check one)

- ☐ Live in a place I own or rent (house, apartment, condo, or townhouse)
- ☐ Live in someone else's place on a temporary basis ("couch surfing")
- ☐ Live in transitional housing (Arcata House or halfway house)
- ☐ Live somewhere as part of a program or treatment (hospital, hotel or motel, respite care, treatment program, jail)
- ☐ Live in emergency shelter
- ☐ Live unsheltered (in a tent, car, around buildings or bridges)

At any time in the last 12 months were you without a regular place to live? (Check one) ☐ Yes ☐ No

2. Information about the people in your household

Please list the names and birth dates of the people in your household. Your household includes people you live and share an income with.

Name	**Birth date**	**MRN** *Office Use*

3. Information about household income

What is your household income before taxes or deductions? This is the total amount earned by all members of your household, including you.

Examples of income (check all that apply):

- ☐ Wages or salary from employment or self-employment
- ☐ Other earnings from employment, such as tips or commissions
- ☐ Child Support
- ☐ Spousal Support
- ☐ Any other source of income_____
- ☐ Alimony
- ☐ Pension or Retirement income
- ☐ Social Security
- ☐ Disability payments
- ☐ Unemployment payments

Total household income: $_____

Is this income (Check one) ☐ Weekly ☐ Monthly ☐ Annually

4. Eligibility for sliding fee discount scale co-payment

Based on your household income reported above you may be eligible for a discount on the fees for your services.

If you are reporting no income above, you must describe your current means of support and/or living situation:

_____

We reserve the right to request evidence of your income in the form of pay stubs, tax returns, or other documents in order to qualify for discounts.

5. Certification and signature

I declare that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services.

Signature: _____ Date: _____

OFFICE USE ONLY SITE_____ Calculated Annual Income_____

Income Verified*: ☐ Yes (Expires 365 days) ☐ No (≤200% FPL-Expires 30days) ☐ No (>200% FPL- Expires 365days)

Notified Patient about eligibility screening and application assistance through Open Door Member Services: ☐ Yes

This applicant is: ☐ Eligible for Discount of: ☐ A Scale ☐ B Scale ☐ C Scale ☐ D Scale ☐ $0 Co-pay**
☐ Not Eligible for Sliding Scale Discount ☐Patient Declined

**$0 co-pay requires re-certification by Office Manager at each visit and cannot be applied to family members.

Termination date: _____ Certified by: Signature: _____ Date: _____

Document eligibility for each family member for each account type within registration.
Enter date eligibility begins (the certification date on this sheet) for each eligible account.
Scan form into Documents under FDS – Financial Document, DESC – FPL.

*ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for SFS≤200% and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS)