KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Sliding Fee Application

Initial Application ☐ Year____ | Renewal ☐ Year____

Today's Date:_____

Applicant's Name: _____ Date of Birth: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone #1: _____ Phone #2: _____

It is the policy of the Knox County Community Health Center (KCCHC) to provide essential medical, mental health, behavioral health, and dental services regardless of the patient's ability to pay. If qualified, a discount may be applied to copayment, co-insurance, and/or deductible balances that are greater than the nominal fee. To qualify for the "sliding fee scale" you must provide proof of household income and the household occupancy. The current nominal fee is $20 for medical services, $10 for mental and behavioral health services, and $20 for dental services.

Please Note: Lab fees are deeply discounted and the actual cost of the lab presented to KCCHC is charged to the patient with no mark-up or additional service fees application.

		Household Income (complete only ONE column per member)*		
Household Members First and last name	***Date of Birth***	***Annual***	***Monthly***	***Bi-Weekly***
Self				
TOTAL INCOME*		$ 0	$ 0	$ 0
# of Dependent Children Under Age 18				

**Income includes all earned income/wages and unearned income including wages, salaries, tips, long term disability, self-employment, unemployment, social security, pensions/retirement, and worker's compensation.*

Total number of members living in your household (self + spouse + children + other qualified members above): ☐

SLIDING FEE DISCOUNT AGREEMENT: I understand and agree that some services rendered are based on my ability to pay. If payment for other services is determined by and based on a sliding fee scale, I understand I am responsible for my share of the cost of services rendered at time of service and that failure to provide "proof of income" will result in me being charged 100% of the cost of services received and/or provided.

I agree, whether as a patient, agent, guardian, relative, or representative, that in consideration of the services rendered, I hereby individually guarantee and obligate myself to pay the account of the KCCHC in full. I further understand that failure to comply with my responsibilities for payment of services rendered may result in suspension of appointments.

I certify that the family size and income information shown above are correct. Copies of tax returns, pay stubs, and or/other information verifying income are required prior to approval of a discount. If defined documentation is unavailable, I will complete and sign the IRS 4506-T form to support this income statement

Signature of Patient/Guardian (If patient is minor): _____ **Date** _____

If Guardian, Relationship to Patient: _____