SNAHC
Sacramento Native American Health Center
a californiahealth+center

Phone 916.341.0575 Fax 916.498.9040
www.snahc.org

Sacramento Native American Health Center (SNAHC)
SLIDING FEE DISCOUNT PROGRAM PATIENT APPLICATION

Sliding Fee Discount Application

It is the policy of SNAHC to provide essential services regardless of the patient's ability to pay. SNAHC offers discounts based on family size and annual income.
Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, Optometry materials and other such services. You must complete this form every 6 months or if your financial situation changes.

Name	
Street	
City	
State	
Zip	
Phone	

Please list all household members, including those under age 18.

Relationship (write in)	Name	Date of Birth
Self		
Other:		
Other:		
Other		
Other		
Other		

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from business and self-employment Unemployment compensation, workers' compensation, Social Security, Supplemental			

Security Income, veterans' payments, survivor benefits, pension, or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
Total Income			

I certify that the family size and income information shown above is correct. I understand that my sliding fee application needs to be updated every 6 months. I agree to apply for Medi-Cal benefits before and if I am not approved that I will be required to provide a denial letter to continue to be eligible for sliding fee discount benefits.

Name (Print):_____

Signature

Date:

OFFICE USE ONLY

Patient Name:_____

Approved Discount Scale:

Approved By:_____

Date Approved:

Evidence Provided:

Income: