



SLIDING SCALE APPLICATION

Please Read: The Sliding Scale Application is intended for those who DO NOT have health insurance coverage that cover our services. Those on Medicare & Medicaid are welcome to apply.

1. You are required to submit documentation of your household's gross annual income in order to be considered for the sliding scale program. *Please note: Social Security #'s are required for processing.
2. It will take approximately 5 business days after receipt of your completed sliding scale application to process your application and update our system.
3. You will be notified by mail regarding your sliding scale program status (qualified/not qualified).
4. If approved, your sliding scale application will automatically expire on May 1st of every year, and you must re-qualify with updated proof of income when it expires.
5. The sliding scale discount is applicable to office visits on teaching shifts and dependent upon clinic policy. *Sliding scale discounts are subject to change.*
6. You must notify the cashier of your approved sliding scale discount at the time of payment. The sliding scale discount will not be applied to past visits or to billing statements.
7. All charges must be paid the day they are incurred. If you do not pay at the time of service, your discount cannot be applied and you will be responsible for the full price of services rendered.

You may qualify for our sliding scale program if your household income is below one of the following income levels <200% of the 2011 Guideline for Federal Poverty Level):

One Person Household	—	\$21,780	Five Person Household	—	\$52,340
Two Person Household	—	\$29,420	Six Person Household	—	\$59,980
Three Person Household	—	\$37,060	Seven Person Household	—	\$67,620
Four Person Household	—	\$44,700	Eight Person Household	—	\$75,260

2. Sliding Scale Application Guidelines:

Use black or blue ballpoint pen. Your completed application must include:

- Age & Social Security Numbers for all household members.**
- Signatures**
- Dates**
- Proof of Income (for each household member over 18 years old & current for the application year). Please provide one of the following:**

- Current W-2 form(s) from all Employers
- Current tax return (must include completed signature & date page of return)
- Current Statement of Monthly Payment for SSI (Social Security), AFS (Food stamps), Unemployment
- 4 months of recent employment pay stubs

(See Reverse Side for Application)

CLINIC USE ONLY

Processed By: _____ Patient Account # _____

Approval Date: _____ Annual Expiration Date: May 1st / yr (_____)

2. Please Print:

Applicant's Name: _____

Household Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Are you employed? [] yes [] no If yes, by whom? _____

Do you have sources of income or financial support other than employment? [] yes [] no
If yes, please list and attach corresponding proof of income:

Including yourself, please circle the total number of people living in your household:

1 2 3 4 5 6 7 8+

Please complete the required fields below for each person living in your household, starting with yourself:

Note: If you do not fill out every field, the application will be returned to you to complete.

Full Name	Social Security #	Birth date	Relation	Gross Annual Income
1. _____	_____	_____	(Self)	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____

Additional Comments:

3. Please Sign:

I certify this information to be a true and accurate account of my household and financial status at this time. I have read and agree to the sliding scale program provisions.

Applicant Signature: _____ Date: _____

Please submit or mail your completed application directly to:

NCNM Community Clinics

049 SW Porter St.

Portland, OR 97201

Phone: 503.552.1711

Fax: 503.499.0023