Fetter Health Care
NETWORK

51 Nassau Street
Charleston, SC 29403
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Self-Declaration Form

Eligibility for Federal Poverty Sliding Fee Adjustment

Patient's: Name: _____

Patient's Data of Birth: _____

Patient's Address: _____

Patient's Telephone Number: _____

Reason for completing this form: □ Self-declaring annual household income and family size
□ Currently not working
□ Not receiving any type of benefits or income

_____ I further declare that no other family member is receiving income/benefits that would pay for services. I understand that when I or any other family members begins receiving any type of benefit, I must report this information to Fetter Health Care Network.

_____ I do not health insurance that will pay for my services. If it is later verified by a Fetter Health Care Network employee to be untrue, the Health Center reserves the right to bill the Insurance Company for all covered dates of services and the patient maybe recommended for dismissal from the health center.

_____ Annual Gross Income: $_____

_____ Family Size_____ (includes the mother, father, and dependent children under the age of 18)

I certify that the information that I provided is correct and I authorize the health center to use it. I understand that this information will be used to determine my eligibility for a Sliding Scale Discount, and if eligible, I will receive a temporary discount for health services for 30 days. I understand that I will be charged at 100% of the medical office visit or pharmacy prescriptions if I do not bring in proper documentations within 30 days.

Patients will not be able to reapply for participation on the Sliding Fee program until they bring in the required documentation for annual income and family size. Prior fees will not be adjusted. Patients will not be able to Self-Declare if completing a secondary application prior to their annual registration date.

I certify that the above information is true and correct to the best of my knowledge. I am also aware that this information may be randomly audited at any time for verification purposes. Knowingly providing false information may result in termination of Sliding Fee Discount Program and/or termination of services at Fetter Health Care Network.

_____ _____
Applicant Signature Date

_____ _____
Financial Eligibility Specialists Signature Date