WELLSPACE HEALTH
Comprehensive care since 1953

PROGRAM SCREENING APPLICATION

	TODAY'S DATE	
1)	Patient Name	Date of Birth
	Address, City, Zip Code	Primary Phone Number
	Social Security Number	Alternate Phone Number
	Employer or Source(s) of Income	Patient Monthly Gross Income

Patient's Household Members

2)	Name	Relationship to Patient	Date of Birth
	Source of Income		Monthly Gross Income
3)	Name	Relationship to Patient	Date of Birth
	Source of Income		Monthly Gross Income
4)	Name	Relationship to Patient	Date of Birth
	Source of Income		Monthly Gross Income
5)	Name	Relationship to Patient	Date of Birth
	Source of Income		Monthly Gross Income
6)	Name	Relationship to Patient	Date of Birth
	Source of Income		Monthly Gross Income

Total number of household members (including patient)	
Total household monthly gross income	**$**

OFFICE USE ONLY

Patient was screened today for the following programs today (select all that apply):

Medi-Cal *CHDP* *Family PACT* *CPSP*

*Patient **encouraged** to apply for the following program(s):* _____

*Patient **previously** applied for following program:* _____

*Date Previously **Denied**:* _____

Share of Cost: _____

*Verifying WellSpace Health Center **Staff** Print Name:* _____

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SLIDING FEE SCALE PROGRAM ELIGIBILITY FORM

If you are uninsured and it is determined that you are not eligible for any public insurance programs like Medi-Cal, you may be eligible for a Sliding Fee Scale program discount. To apply for the Sliding Fee Scale program, you must provide proof of income and sign the affidavit below. All information for this voluntary program is confidential. If you choose to not complete the Program Screening Application (including Proof of Income) you are welcome to be a private pay patient at 100% of cost. Payment is due at time of service.

You must provide Proof of Income within 30 days from date of application to be eligible for future sliding fee scale discounts. If you do not provide Proof of Income within 30 days, you are welcome to be a private pay patient at 100% of cost. Payment is due at time of service. **Your eligibility for the Sliding Fee Scale program is good for 12 months, and must be renewed annually.**

PROOF OF INCOME

One month's documentation of any and all of the following sources of income:

Pay check stubs/statements less than 60 days old	Alimony checks/statements
Signed Statement from employer (if paid in cash)	Interest and/or dividend income statements
Workers Compensation, SDI, Social Security, Unemployment or Pension check stubs/statements	
OR current federal income tax return	

AFFIDAVIT

I understand the services I am receiving today may be billed to me at 100% of the cost.

I further understand that it is my responsibility to provide the Health Center with proof of my household income within 30 days of application for the Sliding Fee Scale program.

If my income is within the Sliding Fee Scale program guidelines, fees may be reduced.

I also understand that I may re-apply if my financial circumstances change at any time.

I certify under penalty of law that the information I've provided is correct.

Patient or Responsible Party Signature	**Date**

OFFICE USE ONLY

*SFS **Approved** Date:_____ (scan supporting Income Verification documentation)*

*SFS **Denied** Date:_____ **Reason**:_____*

*SFS Approved on **30 Day Eligibility** Date:_____ Additional Proof of Income Requested **Due Date**:_____*

SFS Category: ***A ($10)↑*** ***B ($20)↑*** ***C ($30)*** ***D ($40)↑*** ***E($50)*** ***(Full Pay)***

Comments/Notes:

*Verifying WellSpace Health Center **Staff** Print Name:_____*