AccessPointe Community Health Centers

Sliding-Fee Scale Application

Personal Information

Last Name _____ **First Name** _____ **MI** _____

Date of Birth _____/_____/_____ **Social Security Number**_____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ ☐ **Preferred** **Cell Phone** _____ ☐ **Preferred**

Household Information

Spouse Last Name _____ **First Name** _____ **MI** ____

Date of Birth _____/_____/_____ **Social Security Number**_____

List of Dependent Claimed on Your Tax Return

Name	Social Security Number	Date of Birth	Relationship
_____	_____	_____/_____/_____	_____
_____	_____	_____/_____/_____	_____
_____	_____	_____/_____/_____	_____
_____	_____	_____/_____/_____	_____

Proof of Income

You Must Bring Proof of Income ☐ **Most Recent Tax/Return/4506-T** ☐ **Notarized Letter of Support**
☐ **SS/Disability Award Letter** ☐ **Unemployment Award letter** ☐ **Alimony/Child Support Decree**
☐ **Last 3-4 Paystubs from Each Member of House** ☐ **Other** _____

☐ **I have completed this application for sliding-fee eligibility and confirm that all information is correct to the best of my knowledge.**		
Applicants Signature _____ **Date** _____		
☐ **Decline Application?**	**Applicants Signature** _____	**Date** _____

Eligibility Information – For Office Use Only

Annual Gross Income _____ **Number of Dependents** _____

Start Date _____ **End Date** _____

☐ **App Approved** ☐ **Slide A** ☐ **Slide B** ☐ **Slide C** ☐ **Slide D** ☐ **App Denied-Responsible for 100% of Charge**

Processed By _____ **Date** _____

Updated: March 27th, 2025