



**Public Health**  
Prevent. Promote. Protect.

# Tuscarawas County Health Department

## Sliding Fee Discount

### Application

It is the policy of TCHD's Healthcare Clinic to provide essential services. Discounts are offered based on family size and annual income. Please complete the following information and return to the appropriate department to determine eligibility.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes. Immunizations are not included in the sliding fee discount program.

**Applicant Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

<b>Name of Head of Household</b>	<b>Place of Employment</b>
<b>Address</b>	<b>Phone Number</b>

Please list spouse, any related persons living in the household, and any dependents under the age of 18

Name	Date of Birth

**Annual Household Income**

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				0
Income from business, self-employment, and dependents				0
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				0
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				0
<b>Total Income</b>	0	0	0	0

**NOTE: Copies of tax returns, pay stubs, or other information verifying income is required before a discount is approved.**

**I certify that the family size and income information shown is correct. Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

\*\*\*\*\***Office Use Only**\*\*\*\*\*

**Patient/Client Name:** \_\_\_\_\_

**Chart Number:** \_\_\_\_\_

**Sliding Fee Determination:** \_\_\_\_\_

**Approved By:** \_\_\_\_\_

**Date Approved:** \_\_\_\_\_

**Copy of Application and Approval provided to Individual on (date):** \_\_\_\_\_

<b>Verification Checklist</b>	<b>Yes</b>	<b>No</b>
<b>Identification/Address: Driver's license, utility bill, employment ID, or other</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Income: Prior year 1040, two most recent pay stubs, or other</b>	<input type="checkbox"/>	<input type="checkbox"/>