LA MAESTRA
COMMUNITY HEALTH CENTERS
City Heights · El Cajon · National City · Lemon Grove

SLIDING FEE SCALE PROGRAM RULES OF PARTICIPATION

The following items are required to process your application for **La Maestra Sliding Fee Scale Program**. Your application will **NOT** be processed without the requested information. Any information given to La Maestra, will be kept confidential. If the information proves **FRAUDULENT** we reserve the right to cancel your Sliding Fee Scale status and bill you in full for all previous visits.

Information needed for your Sliding Fee Application is as follows:

1. A total number of household members
2. Proof of the household income. All incomes by any household member must be reported

Employment Wages	Social Security	Pensions
Child Support	Alimony	Unemployment, etc.

   We require one (1) current check stub for every household member in the household holding employment. Current meaning not more than 60 days old. If check stubs are not available you must provide a current tax form or statement from the employer on their business letterhead of your gross income or one (1) month's worth of household bank statements including but not limited to checking or savings account.
3. If you have no income you may also provide proof of applying for Medicaid benefits or a copy of Food Stamp Certification.

Before you sign up on the Sliding Fee Scale Program please read the following rules.

THESE RULES MUST BE FOLLOWED WITHOUT EXCEPTION:

1. **LA MAESTRA FAMILY CLINIC, INC. MUST BE NOTIFIED IMMEDIATELY IF:**
   a) **There is a change of income of any family member in the household**
   b) **Any member of the household obtains insurance of any kind**
   c) **There is a change in the number of family members within the household.**
   d) **There is a change in mailing address.**
2. **YOU MUST PAY YOUR CALCULATED FEE AT THE TIME OF EACH VISIT.**
   Your calculated fee is expected at the time of service, in the event that you are not able to pay you will be asked to sign a promissory note and LMFC will send you a bill. Visits that are more complex than originally expected may result in higher a cost. In these instances the balance will be the responsibility of the patient.

I, _____, have read the above rules and agree to follow them. I also understand that if I do not comply with the rules set forth, my participation in the program will be terminated.

Applicant's Signature Date

Signature of LMFC Staff Date

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LA MAESTRA SLIDING FEE SCALE PROGRAM APPLICATION
HOUSEHOLD DATA

Name: _____
Last First MI

Social Security Number: _____

Current Address:_____
No. Street Name City CA Zip Code

Home Phone#: ( )_____ Work Phone #: ( )_____

Permanent Address: _____
No. Street Name City CA Zip Code

Are you or any other household member covered by health insurance, Medical or Medicare? Yes / No

Please list any other members living in the above household:

Name	Date of Birth	Relationship	Sex	Social Security

INCOME DATA

Please list all household members who are employed:

Person Employed	Company Name/Occupation	Monthly Gross Income
Sub Total		**$**

Please list all other sources of income received by any household member:

Other Income/Benefit	Amount
Social Security Benefit	
S.S.I.	
Child Support	
Retirement Pension	

S.S.D.I.	
Unemployment	
Alimony	
Other (specify)	
Grand Total of All Income Received	**$**

Please read carefully before signing:
Verification of income is mandatory. By signing below, I agree that La Maestra Family Clinic (LMFC) may contact each employer of all persons working in the above mentioned household and/or any contact various agencies to verify any source of income. I will provide LMFC a copy of current proof of income. I understand that services will be discounted only after all requested information is provided.
I verify that all information provided on this form is true and correct. A false answer to any portion of the application may jeopardize your status at LMFC and/or punishable by law.
So that LMFC may maintain an updated Sliding Fee Scale Application of file, you will be asked to reapply for the Sliding Fee Scale program on a yearly basis.

_____ _____
Signature Date

Verified and Obtained Information by:

_____ _____
Signature of LMFC Staff Date

Qualified Poverty Percentage	Medical Slide Category	Dental Slide Category	Behavioral Health Slide Category	Optometry Slide Category	Chiropractic Slide Category	Slide Effective Date	Slide Termination Date

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Household Size and Income – Self-Declaration

SLIDING FEE ELIGIBILITY

We appreciate the opportunity to provide you with health services. It is necessary for us to ask personal questions in order to determine if you qualify for a sliding fee discount on the health services rendered. This information is strictly confidential and cannot be released without your permission. In order to qualify for the sliding fee scale, you will need to declare your income annually or whenever there is a change.

Please select one of the following:

☐ I have provided proof of income and declare the number of people supported including myself is _____

☐ I declare that I do not have documentation of my tax returns, pay stubs or other forms of income.
My family's monthly income is $ _____ / ( ) yr. ( ) mo. ( ) wk.
The number of people supported including myself is _____.

☐ I declare that I have no source of income and I am receiving room and board and family size including myself is _____

☐ I refuse to provide financial information and understand that I will be charged full pay for services.

PATIENTS AFFIRMATION OF INFORMATION

I affirm that the information I have provided to La Maestra Community Health Centers is accurate and true to the best of my knowledge. I understand the following:

If I have willfully falsified information, I may be disqualified from the sliding scale program.
If this information changes, I must re-apply with current information.
It is my responsibility to re-determine my eligibility before the expiration date.

Patient's Signature _____ Date _____

Relationship to Patient _____