Denver Indian Health and Family Services. Inc.

2880 W. Holden Place Denver, CO 80204

Phone 303-953-6606 Fax 303-781-4333 www.dihfs.org

Sliding Fee Application Form

Patient Information		**Today's Date: / /**	❑ New Applicant ❑ Renewal
First Name:	Middle:	Last:	Other names:
Home Address:		City:	State: Zip:
Mailing Address:		City:	State: Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -	
Date of Birth: / /	Social Security # - -	Email Address:	
Marital Status: (Circle one)	Single Married Divorced Separated Common Law Partner Widowed Widower		

Household Size				**Do you have Insurance?**
Name	**Date of Birth**	**Social Security Number**	**Related HOW?**	**Name and Policy Number**
SELF	/ /	- -	Self	
	/ /	- -		
	/ /	- -		
	/ /	- -		
	/ /	- -		

Household Income					
Name	**Employer Name**	**Hourly Rate**	**Hours Worked per week**	**Frequency (Circle one)**	**Gross Amount**
SELF		$		Weekly Biweekly Monthly Yearly	$
		$		Weekly Biweekly Monthly Yearly	$
		$		Weekly Biweekly Monthly Yearly	$
		$		Weekly Biweekly Monthly Yearly	$
		$		Weekly Biweekly Monthly Yearly	$

Other Income:	**Name:**	**Name:**	**Name:**	**Name:**	**Monthly Gross Amount**
Social Security					$
Public Assistance					$
Retirement Pension					$
Veterans Benefits					$
Child Support, Alimony					$
Other					$

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Disclaimer

I hereby swear and/or affirm that the information provided on this application is true and correct to the best of my knowledge. I agree that any misleading or falsified information, may disqualify me from further consideration for the sliding fee program. I further agree to inform Denver Indian Health and Family Services. Inc. if there is a significant change in my income. I understand that I must re-qualify annually to maintain my eligibility and/or if any changes in my income.

I authorize Denver Indian Health and Family Services, Inc. to release information regarding treatment to third party payers such as Medicaid, Medicare, or private insurance for the purpose of billing and for any reason in accordance with acceptable medical and other treatment practices, pursuant to the law.

I understand that by receiving services from Denver Indian Health and Family Services, Inc. I am accepting responsibility for payment of charges. Sliding Fee Payments are due before treatment is rendered. ***I understand that the sliding fee discount does not include lab draw, pharmacy or Dental visits.***

If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Denver Indian Health and Family Services, Inc. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____

Client Name (Print): _____

Client Signature: _____ Date: _____

DIHFS Staff Signature: _____ Date: _____

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TO BE COMPLETED BY DIHFS STAFF

OFFICE USE ONLY

House Hold Size: _____ Poverty Level % : _____ Sliding Scale Type: _____ Total Gross Annual Income: $ _____ ❑ **Patient is Eligible for sliding fee discount** **Copay: $_____ Per visit** Discount Effective Date: _____ Re-qualify Date: _____	**Proof of Income:** ❑ Yes ❑ NO **Proof of Documents:** _____ ❑ **Patient does NOT qualify for sliding fee** ❑ **Patient can re-apply if income changes.** ❑ **Patient Refused to complete**	Documents Provided ❑ Paystubs ❑ W-2's Tax form ❑ Other: _____ ❑ Driver's License/ID ❑ SSN Card ❑ Address ❑ **NO Documents provided** _____ Scanned into Chart: ❑ Yes ❑ NO Employee Initials: _____