SIERRA VISTA HOSPITAL

800 East 9th Avenue Truth or Consequences NM 87901
Phone: (575) 894-2111 Fax: (575)894-7659

-SLIDING FEE SCALE APPLICATION-

HOW TO APPLY:

1) Fill out Sliding Fee Scale application completely.
2) Sign and date application.
3) Return the application with your proof of income and all supporting documents.

GENERAL INFORMATION:

- Eligibility for sliding scale fee depends on the following:
  - Number of people in the household
  - Family/ household income.

- Records of all qualified applicants will be maintained with the financial counselor.

- No one will be assigned the Sliding Fee Scale without providing a completed/ updated application and the required financial information.

- Sliding Fee Scale Applies only to clinic office visits. Laboratory, Radiology, Emergency Room, and other charges from the hospital are not included in Sliding Fee Scale Program.

- All applicants are required to re-apply annually or when their financial situation changes.
  - The Sliding Fee Scale will be reviewed in accordance with the institutions fiscal accounting year.

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SLIDING FEE SCALE CHECKLIST:

	Complete & sign SFS application
	Provide Photo ID (Driver's License, Passport, employment ID etc.)
	Insurance Cards (If applicable)

PROOF OF INCOME CHECKLIST: **(Bring only what applies to you & Household)**

	Paystubs (3 most recent)
	Food stamps - General assistance report
	SS or VA benefit awards letter, Or bank statement showing direct deposit (Most recent)
	Disability/ Insurance Income
	Child Support Alimony
	If no income- Notarized affidavit from you/ person helping you financially
	Previous year Federal Tax Return (copy) OR signed 4506-T (No taxes filed form)
	Other income

Sierra Vista Community Health Center

Sliding Fee Scale Application

It is the policy of Sierra Vista Hospital to provide essential services regardless of the patient's ability to pay. We offer discounts based on family size and annual income.

Please complete the following information and return to the Financial Counselor to determine if you or anyone in your family are eligible for a discount. If approved, the discount will apply to all services received at Sierra Vista Community Health Center, but not those services performed outside of the clinic, including labs, radiology, and other such services. You must complete this form every 12 months or if your financial situation changes.

Name of Head of Household:_____

Address:_____ City: _____

State: _____ Zip: _____ Phone: _____

Please list yourself, spouse, and all dependents under age 18.

Name	Date of Birth

Please list all sources of income.

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

Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Signature Date Name (Print)

Office Use Only

Patient Name: _____ Patient ID #: _____

Approved SFS Co-Pay amount: _____ Effective Dates: _____

Approved by: _____ Date Approved: _____

Verification Check List	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or another form		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance cards, Healthxnet verification, portal verification etc.		