Livingstone Community Health Clinic

Discounted / Sliding Fee Application

It is the policy of Livingstone Community Health Clinic (LCHC) to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family income and size. Family size is defined as the number of individuals living within a single residence contributing to or supported by the collective income. The discount will apply to all services received at LCHC but not services which are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. If you feel like this may be a benefit to you and your family, please complete this application and provide verification of income.

Head of Household Information:

Name (Last, First)	Social Security Number	Date of Birth	County
Address	City, State, Zip	Cell Phone	Work Phone
# of people living at home	Marital Status Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐		

Income Information: Please complete for all adult household members who are employed.
Proof of Income (Income tax return and/or last three paystubs) must be provided to LCHC.

Employed Person	Company Name	Income (Before taxes)	Paid how often?
		$	Weekly ☐ Every 2 weeks ☐ Monthly ☐ 2 times per month ☐
		$	Weekly ☐ Every 2 weeks ☐ Monthly ☐ 2 times per month ☐

Other Sources of Income (If applicable)

Alimony	$	TANF	$	Pension/retirement	$
Child Support	$	Disability	$	SSI	$
Social Security	$	Unemployment	$	Other	$

(TANF: Temporary Assistance for Needy Family, SSI: Supplementary Security Income)

Household Information: List ALL individuals in household, including the head of household.

Name	Date of Birth	Relationship	Age	Income	Employed
				$	Yes / No
				$	Yes / No
				$	Yes / No
				$	Yes / No
				$	Yes / No
				$	Yes / No

Medical Application ☐ Dental Application ☐

By signing below, I agree that LCHC staff may contact each employer listed and/or other agencies to confirm my income. I will provide LCHC with proof of income for the purpose of calculating my discount. I will be asked to reapply for the program on an annual basis. I agree to inform LCHC if there are changes to my income, household size, or insurance coverage. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of services. I hereby certify that the information I provide is correct.

Applicant's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Effective Date	
Total Income	
Discount %	

STAFF USE ONLY