GOAD MEDICAL CLINIC
SLIDING FEE DISCOUNT PROGRAM
APPLICATION PACKET

Instructions

Complete all sections. Eligibility is based only on household income and family size compared to current Federal Poverty Guidelines.

Section 1: Patient Information

Patient Name: _____
DOB: _____
Phone: _____
Address: _____

Section 2: Household Composition

Household Size: _____
List all household members below.

Name	Relationship	DOB	Income Source	Annual Income

Section 3: Household Income Verification

Check all documentation provided:

☐ Pay Stubs
☐ Tax Return
☐ W-2
☐ Social Security Award Letter
☐ Unemployment Benefits
☐ Employer Statement
☐ Self-Declaration of Income
☐ Other

Section 4: Self-Declaration of Income

I am unable to provide income documentation and declare that my total household income is $_____ per month. Reason documentation unavailable: _____.

Signature: _____ Date: _____

Section 5: Authorization

I authorize Goad Medical Clinic to verify information necessary to determine Sliding Fee Discount eligibility. I certify all information is true and understand false information may result in denial or termination of assistance.

Applicant Signature: _____ Date: _____

Section 6: Notice of Non-Discrimination

Services are provided without regard to race, color, national origin, sex, age, disability, religion, insurance status, or ability to pay.

Section 7: Federal Poverty Guideline Worksheet

Clinic staff shall enter current annual Federal Poverty Guideline amount for household size and calculated percentage of FPG.

Household Size	Annual Income	FPG Amount	% FPG

Section 8: Eligibility Determination

0-100% FPG: Full Discount (nominal fee may apply)
101-200% FPG: Partial Discount
>200% FPG: No Discount

Eligibility Category: _____ Discount Level: _____
Effective Date: _____ Expiration Date: _____

Section 9: Annual Recertification Form

Patient Name: _____
Current Household Size: _____
Has income changed? Yes/No
Has household size changed? Yes/No
Signature: _____ Date: _____