Healthy Lifestyle Care, NP in Family Health PLLC

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Sliding Fee Discount Program Application

Solicitud del Programa de Descuento de Tarifa Variable

No one will be denied access to services due to inability to pay. Healthy Lifestyle Care offers a Sliding Fee Discount Program based on household income and family size. All information provided is kept strictly confidential. Please complete this application and return it to the front desk along with proof of household size and income.

Nadie será negado acceso a los servicios por incapacidad de pago. Healthy Lifestyle Care ofrece un Programa de Descuento de Tarifa Variable basado en los ingresos del hogar y el tamaño de la familia. Toda la información proporcionada se mantiene estrictamente confidencial.

Section 1 — Applicant Information

Full Name / Nombre completo: _____

Date of Birth / Fecha de nacimiento: _____

Address / Dirección: _____

City / Ciudad State / Estado Zip / Código Postal:

_____

Phone / Teléfono: _____

Email / Correo electrónico: _____

Preferred Language / Idioma preferido: _____

Section 2 — Household Information

Household / Hogar: Include yourself and all family members (spouse, children, and other dependents) who live in your home and share income/expenses.

Name / Nombre	Relationship / Parentesco	Age / Edad	Employer (if any) / Empleador

Total household size (number of people in home) / Tamaño total del hogar:

_____

Section 3 — Household Income

Please report all annual gross income for the entire household, before taxes and deductions. Include wages, self-employment, Social Security, SSI/SSDI, unemployment, child support, alimony, public assistance, retirement/pension, rental income, and any other sources.

Por favor reporte todos los ingresos brutos anuales del hogar, antes de impuestos y deducciones.

Source of Income / Fuente de ingresos	Annual Amount ($) / Cantidad anual
Wages, salary, tips (all household members) / Salarios	
Self-employment / Trabajo por cuenta propia	
Social Security / SSI / SSDI	
Unemployment compensation / Desempleo	
Child support, alimony / Pensión alimenticia	
Public assistance (TANF, SNAP cash, etc.) / Asistencia pública	
Retirement, pension, IRA / Jubilación, pensión	
Rental, investment, or other income / Otros ingresos	
TOTAL ANNUAL HOUSEHOLD INCOME / INGRESO ANUAL TOTAL	

Section 4 — Documentation Provided

Please check all documents you are providing with this application. Self-declaration is accepted when documentation is unavailable.

Por favor marque todos los documentos que está proporcionando. Se acepta una declaración personal cuando no hay documentación disponible.

- ☐ Most recent federal tax return (Form 1040) / Declaración de impuestos más reciente
- ☐ Pay stubs from the last 30 days / Recibos de pago de los últimos 30 días
- ☐ Social Security / SSI / SSDI benefits letter / Carta de beneficios del Seguro Social
- ☐ Unemployment compensation statement / Constancia de desempleo
- ☐ Public assistance award letter / Carta de asistencia pública
- ☐ Written self-declaration of income (when no other documentation is available) / Declaración escrita de ingresos
- ☐ Photo ID for all household members / Identificación con foto para todos los miembros del hogar
- ☐ Proof of address (utility bill, lease, etc.) / Comprobante de domicilio

Section 5 — Patient Attestation

I certify that the information provided on this application is true and accurate to the best of my knowledge. I understand that:

- This information will be used solely to determine eligibility for the Sliding Fee Discount Program.
- All information is confidential and protected under HIPAA.
- My eligibility will be reviewed annually or with any change in household circumstances.
- Providing false information may result in loss of discount eligibility and any past discounts being reversed.
- I will not be denied care while my application is pending.
- I have the right to appeal any eligibility decision within 30 days of the determination.

Certifico que la información proporcionada en esta solicitud es verdadera y precisa, según mi mejor conocimiento.

Applicant Signature / Firma del solicitante: _____

Printed Name / Nombre en letra de molde: _____

Date / Fecha: _____

For Office Use Only

Date Received		**Reviewed By**	
Household Size		**Annual Income**	
% of FPG		**Discount Class (A–F)**	
Discount %		**Nominal Fee**	
Effective Date		**Expires (12 mo.)**	

Reviewer Signature / Firma del revisor: _____

Date / Fecha: _____

This application complies with HRSA Sliding Fee Discount Program guidelines (42 CFR §51c.303). For questions, please contact the front desk or email contact@healthylifestylecare.com.