SHINGLE SPRINGS
Health & Wellness Center
Health Care for All

5168 Honpie Road | Placerville
Office | (530) 387-4975 | sshwc.org

Sliding Fee Discount Application

It is the policy of the Shingle Springs Health & Wellness Center to provide discounted care to those who have limited means to pay. Discounts are offered based upon household size and annual income. Please complete this form and return it to the patient benefit coordinator to determine if you and/or member(s) of your household are eligible for a discount.

The discount will apply to all essential services provided by our facility, but not those services which are purchased from outside, including laboratory testing, prescriptions, and imaging interpretation by a consulting radiologist, and other such services. Some dental fees and procedures may not be eligible for sliding fee discount. This form must be completed annually or if your financial situation changes.

Payment must be made at time of service, or you will be billed the full cost_____ (initials)

Number of related persons living in your household

First Name	Last Name		Employer Name	
Address	City		State	Zip
Phone			Social Security Number	

Dependent is anyone in your household who is 17 years old or younger

Name	Date of Birth	Name	Date of Birth
Self		Dependent 3	
Spouse		Dependent 4	
Dependent 1		Dependent 5	
Dependent 2		Dependent 6	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc				
Social security, pension, annuity and/or veteran benefits				
Alimony, child support, military family allotments				
Income from self- employment or dependents				
Rent, interest, dividend, and other income				
Total Income				

I certify the family size and income information shown above is accurate and complete. Copies of tax returns, paycheck stubs, and other information verifying income is required prior to approval.

Name (Print) _____ Date _____

Signature _____

Office Use Only

Patient Name _____ Discount _____

Date of Service _____ Approved by _____

Verification Checklist (attach copies)	Yes	No
Identification/Address	Driver's license, birth certificate, passport, social security card or other	☐	☐
Income	Prior year tax return, three most recent paycheck stubs	☐	☐
Insurance	Insurance card(s)	☐	☐
Managed Medi-Cal	SSHWC designated as primary care provider	☐	☐
Medi-Cal	Approved application or denial letter	☐	☐
Tribal Verification	Enrollment card, BIA letterhead, judgement	☐	☐