MATTAPAN COMMUNITY HEALTH CENTER
1575 Blue Hill Avenue, Mattapan, MA 02126 | ph. 617-296-0061 | fax. 617-296-5408 | www.mattapanchc.org

Application for Sliding Fee Scale

Patient Information			Today's Date: / /	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

NOTE: Under federal regulations, in order to provide you with a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence.

You must verify your income at least every year.

Your most recent income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Household Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

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I hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Law, which may include fines and imprisonment. I further agree to inform Mattapan Community Health Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all applicable rules and regulations. I hereby acknowledge that I have read and understand the foregoing disclosure

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Date:_____ Name (Print):_____

Signature:_____

Sliding Fee Discount Program Survey

1. How would you rate the helpfulness of our Sliding Fee Schedule and Program in reducing your financial barriers to accessing care at Mattapan Community Health Center? Please circle one:

   Excellent Good Fair Poor

2. Optional: Please take a moment to share your feedback on the effectiveness of this Sliding Fee Discount Program and Schedule in reducing financial barriers to accessing health care services.