R.O.A.D.S.
COMMUNITY CARE CLINIC

Application for Sliding Fee Discount

121 S. Long Beach Blvd. Compton, CA90221Tel #(310)627-5850 Fax # (310) 627-5855

1.Applicant

Name (Last) _____(First) _____(MI) _____

Street Address _____City _____State _____Zip _____

Home Phone _____Date of Birth _____SS # _____

Single _____Married _____Divorced _____Separated _____Widowed _____

2. Household Members *(Spouse/Dependent Children/Relatives/Other)*

Name	Relationship	Birth Date	Social Security #
1.			
2.			
3.			
4.			
5.			

Are you homeless? / Doubling up? Y ____ N___Do you live/work in Los Angeles County Y ____N ____

Are you a College/University student? Y ____N ___ Are you a tourist or foreign student? Y ____N ____

If yes, Can you be claimed as a dependent on someone else's tax return? Y ____N ____

(If yes, additional income verification required)

3. Total Income of Family

(Anyone on your income tax return) Income Calculation

1.Total Household Members Wages/Salary $ _____per_____= $_____

From Sections 1 & 2 _____ Self- employment $ _____per_____= $_____

Unearned $ _____per_____= $_____

2. Total Annual Income $ _____(Specify type)_____

4. Insurance

Do you or your spouse have dental insurance coverage? Y _____N_____ Company _____

Dou you or your spouse have health insurance benefits? Y _____N_____ Company _____

5.Signature

By signing below I give permission to THE R.O.A.D.S. FOUNDATION to share this document and any attachments with THE R.O.A.D.S. FOUNDATION for the purposes of enrollment in its sliding fee schedule. I understand this sharing of information may decrease any out-of-pocket cost to me for services ordered and performed at THE R.O.A.D.S.FOUNDATION (e.g. laboratory testing). I also understand that I may revoke this permission by writing "do not share" next to my signature and that signing this document is not a condition of receiving treatment at THE R.O.A.D.S. FOUNDATION.

To the best of my knowledge, the above information is true and correct. I agree to inform THE R.O.A.D.S. FOUNDATION of any changes in my employment or financial status. If the above information proves to be incorrect, I understand that the discount provided to me will be terminated.

_____

Signature of Applicant **Date**

FOR CENTER USE ONLY

Auth. Initials _____Slide Level _____Approval/Denial Date _____Renewal Date _____

Information about Sliding Scale

What is sliding scale?

A sliding scale is the method we use to offer discounts on healthcare based on a patient's household size and income.

What happens if I don't apply?

You will be asked to pay the full charges for the services provided if you choose not to apply.

How can I prove my income?

a) Payroll check that shows year to date income
b) One month of current pay stubs
c) Current wage statements (written statement from employer)
d) One month of unemployment check stubs
e) Current bank statement that shows flow of money in/out of account
f) Current statement from Social Security office
g) First page of current or previous year income tax forms
h) W2

What if I don't bring proof of income?

Only your first visit with ROADS Community Care clinic will be eligible for a sliding scale discount without proof of income. All other visits will be billed at full fee.

Does the sliding scale change my insurance co-pay, deductible or co-insurance amount?

No, if your insurance company requires that you pay a certain amount as a co-pay, deductible or coinsurance for your services, you must pay that amount.

What if this information changes?

If your income or household size changed, please inform the receptionist. You will be asked to fill out a new application and show proof of new income. Sliding scale rate is valid for 1 year.