	New
	Renewal

SLIDING FEE SCALE APPLICATION

Application Date:	Marital Status:	
Applicant:		MRIN:
Address/State/Zip:		
Home/Cell Phone #:	Work Phone #:	
Message Phone #:	Last AHCCCS Application?	

Please list ALL members of your immediate family:

Last Name	First Name	Date of Birth	Race	Relationship to Applicant	Health Insurance? Y/N? (If so, what type)	Applying for Slide Fee? Y/N
Head of Household:						

Head of Household:		Employer:		Work Phone #:
Paid: ❒ Weekly ❒ Bi-Weekly ❒ Monthly ❒ Other	Gross Amount	Average Weekly Gross	Annual Gross	Monthly Gross
Second Income:		Employer:		Work Phone #:
Paid: ❒ Weekly ❒ Bi-Weekly ❒ Monthly ❒ Other	Gross Amount	Average Weekly Gross	Annual Gross	Monthly Gross
Third Income		Employer:		Work Phone #:
Paid: ❒ Weekly ❒ Bi-Weekly ❒ Monthly ❒ Other	Gross Amount	Average Weekly Gross	Annual Gross	Monthly Gross

Other sources of income (Child Support, Disability, Social Security, Pension, etc.):

Person/Relationship:	Source:	Amount: $
Person/Relationship:	Source:	Amount :$

I understand that if any of the information listed above is found to be untrue or if NOAH is unable to verify my documentation, I may not be eligible to receive any type of service at this facility. I understand that I am responsible for renewing on an annual basis

I understand and acknowledge that I am responsible for any cost associated with medical treatment outside of NOAH, including but not limited to: medications, specialty services (lab, radiology, cardiology, respiratory) and referrals to other physicians.

I agree to pay the co-payment I qualified for at the time of service.

I have had the eligibility requirements explained to me and that all the questions I had were answered. I hereby certify that I understand the requirements in order to receive services within NOAH.

_____ _____

Applicant Signature Date

_____ _____

Eligibility Coordinator Signature Date

FPL level: _____

Effective date: _____

Expiration date: _____

Copays: _____

For Office Use Only

Total # of Family in Household:_____

Total Household Yearly Income: $_____

Eligibility Notes: _____

FPL Calculation: _____

DOCUMENTS ATTACHED

Verified on HEA+ By:_____ Date:_____
(Eligibility Specialist)

❒ Utility Bills qty: ____ or

❒ Rental/Lease Agreement or ❒ Statement from Owner/Renter/Neighbor/Landlord

❒ Bank Statement

❒ Driver's License/Photo ID

❒ Birth Certificates qty: _____

❒ School ID'S

❒ Social Sec Cards qty:_____

❒Passports qty: _____

❒Tax Return yr: _____

❒ Other Medical/ Dental Insurance: _____

❒ _____ ❒ _____

(Types of other insurance: AHCCCS, medical insurance through employer or other family member's employer or any other insurance that would provide medical and/or dental services)

Income: ❒ Paycheck Stub ❒ Employer's Statement ❒ Award Letter ❒ Payment Calendar ❒ Self Attestation