Neighborhood Outreach Access to Health

SLIDING FEE SCALE APPLICATION

Venado Valley Health Center	Desert Mission Health Center	Heuser Family Medicine	Palomino Health Center	Cholla Health Center	Sierra Health Center
20440 N. 27TH Ave Phoenix, AZ 85027	9201 N. 5th St. Phoenix, AZ 85020	7301 E. Second St. # 210 Scottsdale, AZ 85251	16251 N. Cave Creek Phoenix, AZ 85032	11130 E. Cholla St. Bldg. I Scottsdale, AZ 85259	6206 W. Bell Rd Glendale, AZ 85308

Application Date:	Marital Status:
Applicant:	MRN:
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	Gender	Race	Relationship	AHCCCS (Yes/No)	Applying for Slide Fee? (Yes/No)
					(Self)		

Household Income:

Name of Household member:	Person /Company/Source:	Frequency:	Gross Amount: $
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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. If I wish not to provide supporting documentation for family size and income, NOAH may not find me eligible for sliding fee scale program (SFS). I understand that if my household income exceeds 200% of Federal Poverty Level, I or those applying are not eligible for SFS.

I agree to pay the co-payment I qualified for at the time of service. I understand that I am responsible for renewing on an annual basis.

I acknowledge that I gave true and correct answers regarding my family size and income.

_____ _____

Applicant Signature Date

_____ _____

Eligibility Coordinator Signature Date

FPL level: _____

Effective date: _____

Expiration date: _____

For Office Use Only

Total # of members in Household:_____ Total Household Yearly Income: $_____

Eligibility
Notes:_____
_____
_____

FPL
Calculation:_____
_____
_____

DOCUMENTS ATTACHED

Family Size: Government issued ID:

❒ Driver's License/Photo ID

❒ School ID'S QTY:_____

❒ Social Sec Cards qty:_____

❒Passports qty: _____

Other Medical/ Dental Insurance: _____ (Ex. AHCCCS) (if Applicable)

Income:

❒ Paycheck Stub ❒ Employer's Statement ❒ Award Letter ❒ Payment Calendar

❒Letter from income source(child support, spousal maintenance) :_____

❒ Self-Attestation for Self-Employment ❒ Tax Return ❒ No Income Self Attestation

Proof of Bank Account: (Optional)

❒ Checking account statement