



Sliding Fee Scale Eligibility Declaration
We are an equal opportunity provider

Applications will not be accepted unless form is completed and proof of income is provided.

Name (Head of Household) _____

Physical Address _____ City _____ State _____ Zip Code _____

Mailing Address (If different from above) _____ City _____ State _____ Zip Code _____

Primary Phone (_____) _____ Other or Message Phone (_____) _____

Proof of Income Verification - The following list are types of proof that can be used for verification: Paycheck stubs (minimum of one month, preferably three months) Statement from employer as to proof of wages (when check stubs are not used).

Pay Stubs – minimum one month	Most recent Tax Return
Statement from unemployment services, SSI or food stamps	Self-Declaration/Social Declaration (may be filled out below)
Statement of income determination from the Department of Housing	Recent Bank Statement showing income deposits
Annual W-2 wage statements from all income sources	

Household Information (must be completed for all household members)

Number of Household Members: _____

Office Use Only	
Proof of Income	MRN
Y/N _____	_____
Y/N _____	_____
Y/N _____	_____
Y/N _____	_____
Y/N _____	_____

- Name: _____ Date of Birth: __/__/__
- Name: _____ Date of Birth: __/__/__
- Name: _____ Date of Birth: __/__/__
- Name: _____ Date of Birth: __/__/__
- Name: _____ Date of Birth: __/__/__

*Additional family members may be added to the back of this form

Self-Declaration/Social Declaration – To be completed only in the absence of no proof of income

Source of Income (Name of Employer or other income source): _____

Gross Monthly Earnings for **Household** (before taxes): \$ _____

How often do you receive the above income? Daily ____ Weekly ____ Bi-Weekly ____ Bi-Monthly ____ Monthly ____

Has your housing changed dramatically in the past year? Yes ____ No ____

If so, please explain: _____

WE ENCOURAGE APPLICANTS TO MEET WITH OUR OUTREACH STAFF TO DETERMINE WHETHER YOU OR ANY HOUSEHOLD MEMBERS MAY QUALIFY FOR THE OREGON HEALTH PLAN.

ATTESTATION: BY SIGNING BELOW, I ATTEST THAT, AS OF THE DATE OF MY SIGNATURE, THE INCOME SOURCES LISTED CONSTITUTE ALL OF MY HOUSEHOLD INCOME, AND THAT THE HOUSEHOLD MEMBERS LISTED ARE ALL SOLELY DEPENDENT ON THAT INCOME, OR THAT THE EXPLANATION PROVIDED TO VERIFY MY INCOME LEVEL IS TRUTHFUL.

Applicant Signature: _____ Date: _____

Office Use Only

- A: \$25 visit B: \$30 visit + 25% procedures done by LCHC C: \$35 visit + 50% procedures done by LCHC
 D: \$40 visit + 75% procedures done by LCHC E: 25% discount for full payment at time of services

Total Yearly Earnings: \$ _____ Effective Dates: _____ thru _____

Employee Signature: _____