HUDSON HEADWATERS HEALTH NETWORK

9 Carey Road, Queensbury, NY 12804 • (518) 824-8640 • Fax (518) 824-2309

SLIDING FEE PROGRAM APPLICATION

Our sliding fee program helps make financial assistance available to eligible individuals and families receiving healthcare services in our network. To apply, please provide the information and documentation requested below. If you have questions or need help completing your application, please call the number above and we'll be happy to help you.

Applicant:

First and Last Name: _____ Phone Number: _____

Address: _____ Email: _____

City: _____ State: ____ Zip: _____ Date of Birth: _____

Dependents/Household Members:

First and Last Name: _____ Date of Birth: _____

First and Last Name: _____ Date of Birth: _____

Please use the back of this page if you need to add more people. "Household members" are people living in your home.

Please include the following documents with your application:

- **Proof of Medical Insurance (if you have it):** Copies of any medical insurance card(s), if you have insurance coverage. This information will *not* affect your potential sliding fee discount.

- **Proof of GROSS income (for all employed adults on your application):**
  1. Most recently filed Federal Income Tax Returns (Form 1040) with all attachments for all household members listed on your application, including dependents
  2. Paystubs dated within the last 30 days for all employed household members ages 18 and older. In place of paystubs, you may provide one of these other proofs of income:
     - Unemployment determination letter
     - Social Security determination letter
     - Monthly pension statement
     - Monthly rental income statement
     - Monthly/weekly child support statement
     - Monthly alimony statement
     - Other monthly income statement

- **Statement of No Income (for all unemployed adults on your application):** Each unemployed household member age 18 or older must write, date and sign a statement explaining how they are supported.

I give **Adirondack Health Institute (AHI)** permission to contact me to discuss New York State Insurance options: (Medicaid, Child Health Plus, Healthy New York) ☐ **YES** ☐ **NO**

I certify that the information I have given is true and correct. I understand that, by signing this application, I give Hudson Headwaters Health Network permission to verify and confirm this information.

_____

Signature **Date**