

**NEIGHBORHOOD HEALTH CENTER  
155 LAWN AVENUE, BUFFALO, NY 14207 875 2904 X 753**

**APPLICATION FOR SLIDING FEE PROGRAM ELIGIBILITY**

Date of Application: \_\_\_\_\_ Please return by: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Dob: \_\_\_\_\_ Telephone number or Message number: \_\_\_\_\_

Family Members	Relationship	DOB	Employer	AMT / WK MO / YR	SS #

1. Do you have ?      Medicaid      Medicare      IHA      CB      Univera      CHP      BC  
other: \_\_\_\_\_

2. If you have insurance coverage who is the policyholder ? Name: \_\_\_\_\_

3. What is your insurance identification number ? ID#: \_\_\_\_\_

**You must provide proof of income. A copy of any of the following items that you receive is required to process your application: your 4 most current paystubs, most recent tax return or W2's, child support check stubs, social security statements, or disability / workers comp check stubs. Failure to provide sufficient proof will result in the return of your application and delay in approval.**

I hereby request NWBCHCC to make a determination of my eligibility for the sliding fee program. I understand that the information, which I submit concerning my family income and size, is subject to verification. I also understand that if information, which I submit, is determined to be false, I will be liable for all services at full charge. In signing this application I affirm that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform NWBCHCC of all changes in my insurance information and should I fail to do so payment in full will be my responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only: Proof of income provided: Pay___ SS___ Tax___ WC/D___ Fee scale qualified for:_____ Annual income:_____ Date Verified:_____ Initials:_____
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