Canton City Public Health

CANTON CITY PUBLIC HEALTH

Sliding Fee Discount Application

It is the policy of Canton City Public Health (CCPH) to provide essential services regardless of the client's ability to pay. Discounts are offered based on family size and annual household income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount. This form is available in Spanish and other languages upon request.

The discount will apply to most services received at this clinic (it does not apply to travel clinic services or costs of privately purchased vaccines). This form must be completed every 12 months or if your financial situation changes.

Name of Head of Household		Place of Employment	
Address			
City	State OH	Zip	Phone

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT/RELATIONSHIP	
SPOUSE		DEPENDENT/RELATIONSHIP	
DEPENDENT/RELATIONSHIP		DEPENDENT/RELATIONSHIP	
DEPENDENT/RELATIONSHIP		DEPENDENT/RELATIONSHIP	
DEPENDENT/RELATIONSHIP		DEPENDENT/RELATIONSHIP	

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Annual Household Income

Source	Self	Spouse	Other Household Member	Total
Gross Wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension, or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

Note: Copies of tax returns, pay stubs, or other information verifying income *may be* required before a discount is approved.

I certify that the family size and household income information shown above is correct. I understand making a false or misleading statement, or misrepresenting, concealing or withholding facts may result in my paying back the cost of the immunization services provided to me, or the patient identified above for whom I am authorized to make this request.

Name (Print)	Date
Signature	

OFFICE USE ONLY

Verification Checklist	Yes	No
Proof of Address: Driver's license or current photo identification, any utility or credit card bill with patient name (or parent if patient is a minor), business documents that verify place of residency or any document that bears the name and current address of the patient (or parent if patient is a minor).		
Proof of Income: Most current 1040 or W-2, two recent pay stubs (at least one within the last 30 days) if consistent hours (three recent pay stubs if fluctuating hours, at least one within the last 30 days), pension, Social Security Income (SSI), disability, veteran's benefits, retirement, public assistance check stub or copy, unemployment check stub or copy, Workers' Compensation, child support and/or alimony payments (i.e. copy of divorce or dissolution decree).		

Approved Discount Percentage: _____

Approved by: _____ Date Approved: _____