Sacramento County Health Center
Sliding Fee Application

Date:	Date of Birth:
Applicant Name:	
Preferred Language:	Phone:
Address:	
Number of people in my family who reside with me:	I have lived in Sacramento County since:

Household Size and Income					
Name	Relationship	Date of Birth	Employer	Income	Frequency Month, Year

Attached please find my proof of income, family size, residency and a denial for healthcare benefits such as a letter from Medi-Cal.

Signature: _____ Date_____

Staff Section Only		
Total Family Members applying that reside in home:		
Total income:		
Information reviewed:		
	Proof of Sacramento County Residency	Comments:
	Family Size	
	Proof of Income	
	Notice of Action for Medi-Cal or Other Coverage	
	Incomplete – must return documents	
Disposition:		
	100% FPL or under – *Nominal fee*	
	Sliding Fee 101%-125%	
	Sliding Fee 125%-150%	
	Sliding Fee 150%-175%	
	Sliding Fee 176% - 200%	
	Over 200% FPL – *subject to full charges.*	
Member Services Staff:		**Date:**

Original: Patient, Scanned: Chart