



<b>Patient MRN</b>	
--------------------	--

**WAIVER OF SLIDING FEE DISCOUNT**

**Do not** sign below if you wish to be considered for a sliding fee discount.

**I choose not to complete the Sliding Fee Application at this time.** I am waiving my right to any discount for which I may be entitled. I understand that I will be responsible for full payment of all charges at the time of service

Signature

Date

**For Office Use -To be completed by Five Rivers Health Centers' Staff Only**

Please do not write below this line

Proof of Income Provided?	YES	NO
Verification Type		
Gross Annual Household Income		
Family Size		
SFS Income Level:	1	2
	3	4
	5	
Application Approved?	YES	NO
Processed Date:		
Staff Name:		
Staff Signature:		

Notes:

**Next Steps for PARS:**

Add SFS to the "Sliding Fee Scales Count" spreadsheet located in the FRHC PARS team files Sliding Fee Scale Folder

Scan SFS application into the patient's media manager and CC your site's PAR Manager

If approved, send the paper SFS application via interoffice mail to Manager

Complete the patient's FPL information including income and if application is approved or denied

If SFS is approved, add Careassurance to patient's coverages including effective and term dates