Hometown Health Centers
www.hometownhealthcenters.org

SCHENECTADY
1044 State St., Schenectady, NY 12307
600 McClellan St., Schenectady, NY 12304
Tel: (518) 370-1441

AMSTERDAM
67 Division St., Amsterdam, NY 12010
Tel: (518) 627-2110

Sliding Fee Discount Program Application and Self-Declaration

Sliding fee discounts are offered depending on family size and income. The discount will apply to most of the services provided at the health center. Services provided by other organizations such as laboratory testing, prescriptions, x-rays, specialists, and similar services **do not** apply to this program. The information used to determine your eligibility must be updated every twelve (12) months.

Select one:
☐ Self-Declaration only, valid for one day only
☐ Sliding Fee Program enrollment, valid for 12-months from the date the application is completed

Household Information

List all household family member names, dates of birth and income information.

Name	Date of Birth	Relationship	Income $	How Often? Weekly / Bi-weekly / Monthly / Yearly	Source of Income

FOR OFFICE STAFF TO COMPLETE					
Total # of Household Members (Family Size):		**Total Gross Household Income:**	$	**Frequency of Household Income:**	

List income from all sources which may include: wages/employment earnings, tips, self-employment wages, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income (SSI), public assistance, veteran's payments, pension benefits, survivor's benefits, pension or retirement income, trust fund disbursements, training stipends, scholarships, grants, and all other forms of financial support. Non cash benefits such as food stamps do not count.

Self-Declaration for Sliding Fee

Must complete if no proof of income is available. Self-declaration is accepted for **ONE DAY ONLY**, the date the application is completed. All subsequent visits will be charged at the full fee unless proof of income is provided.

Affidavit

By signing below, I certify that, as of the date of my signature, the family size and income listed is truthful. I also certify that all of my household income and family members are all solely dependent on that income. Copies of paystubs, tax returns, and other information verifying income are required before a discount is approved.

Name (Print):		
Signature:		Date:

FOR OFFICE STAFF TO COMPLETE
Level of Discount: ☐ Nominal fee only (A | SF MIN) ☐ 90% (B | SF10) ☐ 80% (C | SF20) ☐ 60% (D | SF40) ☐ 40% (E | SF60) ☐ 20% (F | SF80) ☐ 10% (G | SF90)
Valid: From: _____ To: _____ **Staff Signature:** _____