



Escambia Community Clinic \* Santa Rosa Community Clinic \* Cantonment Medical Center  
Urgent Care \* Lanza Pediatrics \* ECC Lakeview Campus \* First Steps Pediatrics \* ECC Dental Clinic  
ECC at Waterfront Rescue Mission \*ECC Women’s Health Clinic

Dedicated to Meeting the Health Care Needs of Our Community Since 1992

### Sliding Fee Discount Program

The following items are **REQUIRED** to process your application for the Sliding Fee Discount Program. Your application will **NOT** be processed without the requested information. Any information given to Escambia Community Clinics, Inc. or any of its locations will be kept confidential. If the information proves to be **FRAUDULENT** we reserve the right to cancel your Sliding Fee Scale status and bill you in full for all previous visits. Information needed (CHECKLIST):

1. \_\_\_\_\_ Complete Financial Assistance Form (front and back)
2. \_\_\_\_\_ Copy of photo ID
3. \_\_\_\_\_ Copy of at least (1) one paycheck stub from Husband & Wife
4. \_\_\_\_\_ Copy of current year income tax return (if filed) – not “W2”
5. \_\_\_\_\_ Copy of Food Stamp eligibility letter
6. \_\_\_\_\_ Proof of Resident (utility bill or mail at the address in applicants name)
7. \_\_\_\_\_ Proof of SSI disability income, (the awards letter) child support, or unemployment, etc.
8. \_\_\_\_\_ Anyone in the household over the age of 18 that is unemployed must provide a written “letter of support” or homeless ID card

**BEFORE SIGNING, PLEASE READ THE FOLLOWING:**

Escambia Community Clinics, Inc. or its satellite locations must be notified immediately if:

- a. There is a change of income (increase or decrease) of any family member in the household listed on original application.
- b. Any member of the household, if listed on original application, obtains insurance of any kind.
- c. There is a change of mailing address or phone number.

**You must pay your fee at the time of each visit.** If you do not pay your fee or are not qualified during the current visit, you **MUST** pay the balance of your account and/or bring in the required documents within 7 business days. If payment or documentation is not received, Escambia Community Clinics, Inc. or its satellite locations reserves the right to **TERMINATE** your eligibility in the Sliding Fee Discount Program and pursue further collection efforts.

\_\_\_\_\_  
Applicant’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Financial Counselor’s Signature

\_\_\_\_\_  
Date



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**PATIENT REGISTRATION FORM**

Patient Name: \_\_\_\_\_

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

Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Sex: M F DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Marital Status: Single/Married/Separated/Divorced

Spouse: \_\_\_\_\_ DOB: \_\_\_\_\_

African American  White/Caucasian  Asian  More than one race

Native Hawaiian/Other Pacific  American Indian/Alaska Native

Are you Hispanic? Yes No (Please circle one)

Emergency Contact: \_\_\_\_\_  
Name Phone #

Does the patient have any type of medical insurance? (Please circle one) Yes No If yes, please circle

Medicaid Share of Cost Family Planning Medicare Disability Other

I declare the information contained on this form to be true and correct to the best of my knowledge and consent to the verification of this information by Escambia Community Clinics, Inc. or its satellite locations. I also authorize Escambia Community Clinics, Inc. or its satellite locations to release any information to any insurance company, the Florida Division of Family Services, Center for Medicare and Medicaid Services or any of their respective agencies that I may have designated as providing insurance in order to secure payment for any treatment provided by Escambia Community Clinics, Inc. or its satellite locations.

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

**Office Use Only**

Monthly Income: \_\_\_\_\_ # in household: \_\_\_\_\_

Approved financial classification: \_\_\_\_\_ Financial Counselor initials: \_\_\_\_\_



# ESCAMBIA COMMUNITY CLINICS, INC.

A FEDERALLY QUALIFIED HEALTH CENTER  
Proudly providing healthcare since 1992

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## Certification of Low Income Status Income Assessment Worksheet

Please list income for all dependent family members. This does not include guests, roommates or non-dependent family members.

Source	Amount	Weekly	Bi-Weekly	Monthly	Annually
Salaries and Wages (Self)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salaries and Wages (Spouse)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Compensation	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Security (Self/Spouse)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Security (Children)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Support/Alimony	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Military/Veterans Benefits	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public Assistance	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Stamps	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pension/Retirement	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list all dependent family members by NAME, DATE OF BIRTH AND SOCIAL SECURITY NUMBER.

### Please include yourself.

Name	Date of Birth	Social Security Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Escambia Community Clinics, Inc. reserves the right to inspect your tax return and/or wage statements for previous periods upon request. Eligibility will be updated on an annual basis. If there are any changes in your income status prior to your annual update, you should notify ECC immediately.

I hereby certify that the income and family composition information supplied in the above table is true and correct to the best of my knowledge. I understand this document will be maintained for a period of one year and that falsification of information may result in termination of my eligibility in the medical assistance program (sliding fee schedule).

Signature \_\_\_\_\_

Date \_\_\_\_\_