

# FRIEND FAMILY HEALTH CENTER, I NC.



|   |  |  |  |   |
|---|--|--|--|---|
| 800 E. 55 <sup>th</sup> STREET<br>CHICAGO, IL 60615<br>Phone: (773) 702-0660<br>Fax: (773) 702-4356 | 5843 S. WESTERN AVE<br>CHICAGO, IL 60636<br>Phone: (773) 434-8600<br>Fax: (773) 434-0600 | 25 W. 47 <sup>th</sup> STREET<br>CHICAGO, IL 60609<br>Phone: (773) 536-4879<br>Fax: (773) 536-5201 | 5635 S. PULASKI<br>CHICAGO, IL 60629<br>Phone: (773) 585-3900<br>Fax: (773) 585-7332 | 2436 W 47 <sup>th</sup> STREET<br>CHICAGO, IL 60632<br>Phone: (773) 376-9400<br>Fax: (773) 376-9693 |
|---|--|--|--|---|

## SLIDING FEE SCALE PROGRAM INFORMATION SHEET

The Friend Family Health Center is Federally Qualified Health Center whose mission includes improvement of the overall health status of the community it serves and providing quality healthcare. We realize that many families are uninsured and are unable to afford medical care. We at FFHC offer a discount program to those who are uninsured and unemployed. FFHC discount program is based on your household income and family size. Your discount can be 20%-100% of services provided on-site. If you qualify for a 100% discount then you will be required to pay \$25.00 co-pay for each visit with an MD (Medical Doctor), NP (Nurse Practitioner) or MNT (Medical Nutrition Therapist) or RD (Registered Dietician). Fees are only discounted on the services that Friend Family Health Center renders, which means that medications, hospital services and other diagnostic services are not covered under the sliding fee scale program.

If you or any of your friends and/or family members need healthcare services please speak to them about our facility and the Sliding Fee Scale program. For more information speak to any front desk staff member they'll provide you with detailed information about the program and qualification requirements.

# FRIEND FAMILY HEALTH CENTER, I NC.



|   |  |  |  |   |
|---|--|--|--|---|
| 800 E. 55 <sup>th</sup> STREET<br>CHICAGO, IL 60615<br>Phone: (773) 702-0660<br>Fax: (773) 702-4356 | 5843 S. WESTERN AVE<br>CHICAGO, IL 60636<br>Phone: (773) 434-8600<br>Fax: (773) 434-0600 | 25 W. 47 <sup>th</sup> STREET<br>CHICAGO, IL 60609<br>Phone: (773) 536-4879<br>Fax: (773) 536-5201 | 5635 S. PULASKI<br>CHICAGO, IL 60629<br>Phone: (773) 585-3900<br>Fax: (773) 585-7332 | 2436 W 47 <sup>th</sup> STREET<br>CHICAGO, IL 60632<br>Phone: (773) 376-9400<br>Fax: (773) 376-9693 |
|---|--|--|--|---|

## Sliding -Fee Scale Documentation Checklist

The following items are required to determine eligibility for the Sliding Fee Scale Program. These items must be submitted to the Clinic Coordinator prior to your appointment. All items checked must be submitted to qualify for discounted services.

### All Applicants

- Photo ID
- Family Size
- Income Verification
- Social Security Card

### Employed Applicants

- Current consecutive pay-stubs (minimum 3)
- Copy of most recently filed Income Tax Return
- Employer signed statement of itemized earnings

### Unemployed Applicants

- Current consecutive unemployment check stubs (minimum 2)
- A letter from the individual whom supplies food and shelter to the applicant. The letter must be accompanied by proof of residency and include the Social Security # of the signor.

### Retired/Disabled Applicants

- Social Security award letter
- Statement of retirement benefits from the issuing agency(ies)

# FRIEND FAMILY HEALTH CENTER, I NC.



800 E. 55<sup>th</sup> STREET    5843 S. WESTERN AVE    25 W. 47<sup>th</sup> STREET    5635 S. PULASKI    2436 W 47<sup>th</sup> STREET  
CHICAGO, IL 60615    CHICAGO, IL 60636    CHICAGO, IL 60609    CHICAGO, IL 60629    CHICAGO, IL 60632  
Phone: (773) 702-0660    Phone: (773) 434-8600    Phone: (773) 536-4879    Phone: (773) 585-3900    Phone: (773) 376-9400  
Fax: (773) 702-4356    Fax: (773) 434-0600    Fax: (773) 536-5201    Fax: (773) 585-7332    Fax: (773) 376-9693

## SLIDING FEE APPLICATION

Applicant's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

D.O.B: \_\_\_\_\_

\_\_\_\_\_

Account #: \_\_\_\_\_

Phone #: \_\_\_\_\_

S.S. # \_\_\_\_\_

.....  
GROSS MONTHLY INCOME: \$ \_\_\_\_\_

SOURCE OF INCOME

Family Size \_\_\_\_\_

Employment: \$ \_\_\_\_\_

Employer \_\_\_\_\_

Unemployment Comp: \$ \_\_\_\_\_

Address \_\_\_\_\_

Worker's Comp: \$ \_\_\_\_\_

\_\_\_\_\_

Social Security: \$ \_\_\_\_\_

Phone Number \_\_\_\_\_

Veteran's Aid: \$ \_\_\_\_\_

Pension: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

RESPONSIBLE PARTY'S SIGNATURE \_\_\_\_\_

.....  
FOR OFFICE USE ONLY

## FEE DETERMINATION

SCALE: \_\_\_\_\_

ELIGIBILITY DATES: \_\_\_\_\_

SCALE: \_\_\_\_\_

ELIGIBILTY DATES: \_\_\_\_\_

COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

APPROVING STAFF MEMBER'S SIGNATURE \_\_\_\_\_

# FRIEND FAMILY HEALTH CENTER, I NC.



|   |  |  |  |   |
|---|--|--|--|---|
| 800 E. 55 <sup>th</sup> STREET<br>CHICAGO, IL 60615<br>Phone: (773) 702-0660<br>Fax: (773) 702-4356 | 5843 S. WESTERN AVE<br>CHICAGO, IL 60636<br>Phone: (773) 434-8600<br>Fax: (773) 434-0600 | 25 W. 47 <sup>th</sup> STREET<br>CHICAGO, IL 60609<br>Phone: (773) 536-4879<br>Fax: (773) 536-5201 | 5635 S. PULASKI<br>CHICAGO, IL 60629<br>Phone: (773) 585-3900<br>Fax: (773) 585-7332 | 2436 W 47 <sup>th</sup> STREET<br>CHICAGO, IL 60632<br>Phone: (773) 376-9400<br>Fax: (773) 376-9693 |
|---|--|--|--|---|

## UNEMPLOYED AFFIDAVIT

Date: \_\_\_\_\_

This letter verifies that \_\_\_\_\_ is presently unemployed and  
have no income. I \_\_\_\_\_, social security number (last 4 digits):  
\_\_\_\_\_ am contributing to his/her support.

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

# FRIEND FAMILY HEALTH CENTER, I NC.



800 E. 55<sup>th</sup> STREET  
CHICAGO, IL 60615  
Phone: (773) 702-0660  
Fax: (773) 702-4356

5843 S. WESTERN AVE  
CHICAGO, IL 60636  
Phone: (773) 434-8600  
Fax: (773) 434-0600

25 W. 47<sup>th</sup> STREET  
CHICAGO, IL 60609  
Phone: (773) 536-4879  
Fax: (773) 536-5201

5635 S. PULASKI  
CHICAGO, IL 60629  
Phone: (773) 585-3900  
Fax: (773) 585-7332

2436 W 47<sup>th</sup> STREET  
CHICAGO, IL 60632  
Phone: (773) 376-9400  
Fax: (773) 376-9693

## MEDICARE AFFIDAVIT

**Date:** \_\_\_\_\_

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

**Account#:** \_\_\_\_\_

**This letter verifies that I, \_\_\_\_\_ live on a fix income  
of (amount) \_\_\_\_\_ and unable to pay the remaining of my medical bill**

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