



Email: registration@odhc.org

Fax: 507-388-5901

Address: 309 Holly Lane, Mankato, MN 56001

SLIDING FEE DISCOUNT PROGRAM APPLICATION

You may qualify to pay a reduced price for some services and treatments at our health centers. The exact amount you pay depends on your income and family size. This is the "Sliding Scale". All patients, with or without insurance, are encouraged to complete an application to participate in our federal grant. Once you qualify for the Sliding Scale, you can use it for 12 months. If your income or household size changes during those 12 months, you must let us know.

Would you like to apply for our Sliding Fee Discount Program? YES NO

What services have you/your family received from ODHC? MEDICAL___ DENTAL___ BEHAVIORAL HEALTH___ CHIROPRACTIC___

Today's date: _____ Name of Guarantor: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Social Security Number: _____

Are you currently employed?	YES	NO
Is anyone else in the household employed?	YES	NO
Does anyone in the household receive State or Federal benefits (cash benefits, SSI, etc)?	YES	NO
Does anyone in the household receive any other sources of income?	YES	NO
Total monthly income of the household Please see back of sheet for Proof Requirements	\$	No Income

LIST BELOW ALL MEMBERS OF THE HOUSEHOLD – INCLUDING DOB AND RELATIONSHIP

FAMILY MEMBER NAME Enter yourself in the first line labeled SELF	DATE OF BIRTH	RELATIONSHIP TO APPLICANT
		SELF

I, the applicant, agree to inform ODHC if there is any change in my household income at any time. I understand that it is my responsibility to supply all requested information, which may include W-2 forms as well as my tax return. I also understand that if I do not have the required information at my next visit, I will be taken off the Sliding Scale until such information is submitted.

Guarantor's Signature _____ Date _____

Review and Calculation of Application by (ODHC Staff): _____ Date _____