Health Care System

Huntsville Family Health Center
751 Pleasant Row
Huntsville, AL 35816
p 256-533-6311

Athens Family Health Center
1005 W. Market Street, Suite B
Athens, AL 35611
p 256-230-3061

New Market Clinic
110 Clinic Street
New Market, AL 35761
p 256-379-2101

Toney Family Health Center
8208 Highway 53
Toney, AL 35773
p 256-851-8804

ADJUSTABLE PAYMENT PLAN/SLIDING FEE DISCOUNT APPLICATION

It is the policy of Central North Alabama Health Services, Inc. (CNAHSI) for its health centers to provide essential services regardless of the patient's ability to pay. Adjustments/discounts are offered based on family size and annual income. Please complete the following information and return to the front deck to determine if you or members of your family are eligible for a discount.

The adjustment/discount will be apply to all services received at our health centers, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

Please list spouse and dependents under age 18.

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.				
TOTAL INCOME				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (Print) _____

Signature _____ **Date** _____

OFFICE USE ONLY

Patient Name: _____

Approved Discount: _____ **Required Payment Visit:** _____

Approved By: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's License, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		