Eligibility Determination for Sliding Fee Discounts

It is Harmony Healthcare Long Island, Inc. (HHLI) policy to provide essential services to all patients regardless of the patient's ability to pay. Discounts are set by the HHLI consumer Board of Directors and are offered based on the information you provide regarding your family size and income. If you are eligible for a sliding fee discount, it will apply to all services received at HHLI, but not for those services provided outside the Health Center.

Please complete the following information, even if you have insurance.

Household Income Before Taxes

HOUSEHOLD MEMBER	NUMBER	MONTHLY INCOME	YEARLY INCOME
Self Name:			
Spouse			
Dependent Children			
Other dependents			
Total			

☐ I am declining to provide information on my income and family size and agree to pay the full HHLI fee.

ACCEPTABLE PROOF OF INCOME IS REQUIRED FOR THE SLIDING FEE DISCOUNT PROGRAM. IF YOUR FINANCIAL SITUATION CHANGES, PLEASE KEEP HHLI INFORMED.

☐ I certify that all information shown above is true, accurate and correct. I understand that if HHLI determines that misrepresented or falsified information, I will no longer receive discounts and may be asked to pay back discounts

☐ I agree to provide documentation of my income at my next visit.

Name (print) _____ Signature: _____

Witness: _____ Date: _____

Staff to complete information below

1. Eligible for Sliding Fee Discount: Yes _____ No _____ Patient Refused _____ _
2. If yes, acceptable proof of income provided: Yes _____ No _____ Patient Refused _____
3. If insured, Health insurance card provided: Yes _____ No _____ Not applicable _____
4. Patient reports no income Yes _____
5. Patient is unable to obtain proof from an employer (This includes paid in cash/off the books earnings) Yes _____ _

If yes, to either question 4 or 5, please fill out the attached Self-Attestation Form

Family Planning Sliding Scale Code (SS1- SS5 or N/A) _____

516-296-3742
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