KONZA PRAIRIE Community Health Center

Sliding Fee Discount Program Application

Patient name: _____ Date of Birth: _____
Last, First, Middle Initial

As part of KPCHC's mission, we ensure no patient is denied care based on their ability to pay. KPCHC reviews income **annually** to determine discount eligibility.

- At the time of service, a nominal fee is due, and other charges may be incurred and billed.
- Federal grant guidelines require KPCHC to exhaust 3rd party payers (insurance) before applying discounts.

Economic unit: Please list all members of your household supported under same income.

	Name:	Date of Birth:	Relationship:	Insurance:
1.				Yes No
2.				Yes No
3.				Yes No
4.				Yes No
5.				Yes No
6.				Yes No

Please initial one of the following if it pertains to you: *(If none of the following statements pertain to you, please follow the directions listed in Income section below.)*

_____ By initialing this line, I declare that my household is currently receiving assistance from one or more of the following programs and am providing a current award letter. I understand that program participation will be used to help verify household income for SFDP eligibility and am also providing my attested total household income and household size. **Examples of such programs include, but are not limited to:**
Kansas Medicaid; SNAP; TANF; Kansas Farmworkers Program;WIC; Housing Assistance; LIEAP and documentation from a homeless shelter verifying current residence.

I declare my annual gross income to be $_____for _____ people in my household
_____ I am a student under the age of 18 years old and do not have an annual income greater than $12,000.
_____ I do not have my income documentation today. I declare my monthly income to be $_____for _____ people in my household. I will present household income to receive future discounts. This declaration is good for **one day per year.**

Income: We require documentation of income to finalize the application process to be submitted no later than two weeks from signing this application. Income sources may include the following: up to three most current paystubs, W2, income tax returns, government assistance documents, employer letter on letterhead, child support, alimony, pension, and/or letter from government agencies.

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me from discounts, and I will update KPCHC if there are any changes to my income.

Patient/Guardian Signature: _____ Date: _____

Internal Use Only:

Sliding Fee Scale:	Expiration date:	Staff initials:
Dental/Medical: B C D E F		
Family Planning: B C D E F	_____	_____

Updated: January 2026