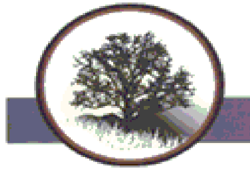


MATHIESEN MEMORIAL HEALTH CLINIC
P.O.Box 535,18144 Seco St.
Jamestown, CA 95327

Sliding Fee Scale Application

Reduced fee determination worksheet

For some qualified families, medical services are available at a reduced fee, which is determined by the size of your immediate family and your present income. The primary requirement for consideration is that you have been DENIED by Medi-Cal within the last 60 days. If you currently have Medi-Cal, DO NOT complete this form.

Patient Information			**Today's Date: / /**		
First Name:	Middle:	Last:	Other names:		
Mailing Address:		City:	State:	Zip:	
Home Phone #: ( ) -		Cell Phone #: ( ) -			

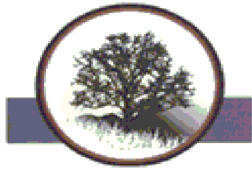
Total number of dependents living in your household; include yourself, spouse, children, and any dependent relatives living with you.

Name	Date of Birth	AGE	Relationship
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

Household Income

Name	Amount	Frequency (Circle one)	Source
You	$	Monthly Yearly	
Spouse	$	Monthly Yearly	
Children	$	Monthly Yearly	
Other	$	Monthly Yearly	
Other	$	Monthly Yearly	
TOTAL	$	Monthly Yearly	

Phone 209-984-4820
Fax 209-984-4825



MATHIESEN MEMORIAL HEALTH CLINIC
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Please return this completed form to Mathiesen Memorial Health Clinic. Along with the following

1. **Copy of your Medi –Cal Denial and**
2. **Three current bank statements, pay stubs for three previous months or previous year tax return for income verification.**

Failure to provide sufficient proof will result in the return of your application and delay in approval.

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Mathiesen Memorial Health Clinic if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Mathiesen Memorial Health Clinic. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____________________________________

Name_____________________________________

Signature:____

Phone 209-984-4820
Fax 209-984-4825

MATHIESEN MEMORIAL HEALTH CLINIC
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Jamestown, CA 95327

VERIFICATION AND DETERMINATION
OFFICE USE ONLY

Applicant Name:___________________________________

1. ☐ Copy of Medi-Cal denial form attached
2. ☐ Monthly/yearly income verification attached

3. ☐ Yearly income computation completed for:

☐ Applicant	$_____________
☐ Spouse	$_____________
☐ Other	$_____________
Total Yearly Income	$_____________

Fee Reduction Recommendation
- A. 100%
- B. 75%
- C. 50%
- D. 25%
- E. 0%

Length of Reduction
- A. 90 Days
- B. 60 Days
- C. 30 Days

Verification and determination by______________________________ Date_____________
Verification Employee

Phone 209-984-4820
Fax 209-984-4825