EAST TEXAS COMMUNITY HEALTH SERVICES, INC.

Sliding Fee Discount Declination Form

I understand it is the policy of East Texas Community Health Services, Inc. (ETCHSI) to remove income as a barrier to care by offering a sliding fee discount schedule (SFDS). The policy and eligibility guidelines have been explained to me; nonetheless, I decline to provide required income information and/or documentation to verify my eligibility, or I did not qualify for the SFDS. I understand this means I will be charged full fee for all services rendered; including those which are not covered by my healthcare insurance plan, if applicable. I also understand this declination and my household status must be updated annually.

_____ _____

Patient Name Date of Birth

_____ _____

Guarantor Name Date of Birth

_____ _____

Signature of Responsible Party Date

Family Size_____ Annual Income _____

INTERNAL USE ONLY

_____ _____ _____

Patient Account Number Reviewed by Date

Patient declined SFDS _____ Patient did not qualify for SFDS _____