LONE STAR FAMILY HEALTH CENTER

605 S. Conroe Medical Drive
Conroe, Texas 77304
936-539-4004

440 Rayford Rd, Suite 150
Spring, Texas 77386
936-539-4004

201 Lincoln Ridge
Willis, Texas 77378
936-539-4004

13905 Grangerland Rd
Conroe, TX 77306
936-539-4004

Requirements for Sliding Fee Scale Applications

The information below is required by the Eligibility Department at Lone Star Family Health Center to determine if you qualify to receive discounted services that can be provided under the Sliding Fee Scale program:

1. Completed application that includes the names of all household members.
2. A copy of a current driver's license, birth certificate, passport, voter registration card, and/or other ID card from your country of origin.
3. Copies of Medicaid, Medicare, Insurance ID Cards for your household members.
4. Proof of Residence. This can be given through the following documents:
    a. A copy of most recent utility bill
    b. Lease or mortgage documentation
5. Proof of income for all individuals living at the address (even if not currently employed). This can be given through the following documents:
    a. 2-3 current paycheck stubs
    b. A typed and notarized letter from the applicant stating your current wages per week if you are paid cash for services and not able to provide paycheck stubs
    c. A typed and notarized letter from your employer stating your dates of employment and wages if you are paid cash and not able to provide paycheck stubs
    d. The previous year tax return including Schedule C– if self employed
    e. If not employed, please provide wage statement from Texas Workforce Solutions
    f. A pre-paid pay card statement or transaction record if you are paid by pay cards
    g. Award letter for Social Security, disability, pension, retirement, or unemployment benefits
    h. Child support letter
    i. Completed and signed Statement of Support with picture ID of individual that supports you.

Please note that we follow the Federal guidelines established by the U.S. Government to determine your eligibility**.** This is not a health insurance and does not meet the Affordable Care Act requirement for having health coverage. ***Falsification of any information and/or documentation will disqualify you from receiving any services under Sliding Fee Scale.*** Please sign and date below stating that you understand the requirements of this program. By signing this document I authorize Lone Star Family Health Center to obtain a credit report to assist in determining Sliding Fee Scale Eligibility.

_____ _____

Applicant's Signature Date

_____ _____

Applicant's Printed Name Applicant's Date of Birth