FINANCIAL AID APPLICATION

As a Federally Qualified Health Center, Health Partnership Clinic (HPC) offers patients the opportunity for discounted fees determined by household size and annual household income. The Financial Assistance Application must be completed in full and all required documentation submitted within 30 days of the application date. Patients with incomplete applications after 30 days will have eligibility revoked and be billed full charges. HPC requires re-verification of household size and income <u>every 12 months – or earlier if there is a change</u>.

Household Address:

_____

Street Address Apt/Unit City State Zip

(____)_____ (____)_____

Primary Phone Number Home/Work/Cell Secondary Phone Number Home/Work/Cell

<u>Please List All Household Members</u>: **Total # of Household Members:_____**

Name:	Date of Birth:	Relationship:	Employed:	HPC patient?
(Head of Household)			YES / NO	YES / NO
(Patient)			YES / NO	YES / NO
			YES / NO	YES / NO
			YES / NO	YES / NO
			YES / NO	YES / NO

Initial Here _____ ***Families larger than 5 request additional form***

<u>Please Provide All Household Income Information</u>:

Proof of income MUST be provided within 30 days of the date of this application. If my application is incomplete at my first visit, I will be required to pay the nominal fee, per the current Health Partnership Clinic Sliding Fee Discount Schedule, for the type of services I receive. I understand that upon completion, my sliding fee level will be assigned and could result in a balance due if I do not qualify for the nominal fee or I am ineligible for a discount. If my proof of income is not submitted within 30 days, my eligibility will be revoked and I will be billed full charges.

Initial Here _____

Earned Wage Income in the Household: (Please list everyone in the household receiving income)

Sources: Who has income in the house?	Company Name:	Income: Gross wages, which includes base pay, overtime, holiday and vacation pay.	Indicate how often each person is paid: Weekly, Monthly, 2 times a Month, Every 2 Weeks?
You:		$	
Spouse/Significant Other:		$	
Additional Person(s):		$	
Additional Person(s):		$	

Other Sources of Household Income: (Please list everyone in the household receiving other sources of income)

Type:	You:	Spouse:	Other:	Total:
Social Security	**$**	**$**	**$**	**$**
Public Financial Assistance	**$**	**$**	**$**	**$**
Retirement Pension	**$**	**$**	**$**	**$**
Business Income, self-employment, and dependents:	**$**	**$**	**$**	**$**
Unemployment, worker's compensation, disability, strike benefits, etc.:	**$**	**$**	**$**	**$**
Rental Income:	**$**	**$**	**$**	**$**
Child Support – Alimony:	**$**	**$**	**$**	**$**
Educational grants, loans, and awards:	**$**	**$**	**$**	**$**

If your income is $0, how are you meeting your food, clothing, shelter, and transportation needs?

_____

Initial Here _____

Verification Checklist Item:	YES	NO
Identification: driver's license, birth certificate, employment ID, SS Card, etc.		
Proof of Address: utility bill, bank statement, phone, or cable bill.		
Income: prior year tax return(s), most recent paystubs to equal one month's pay, social security benefits letter, unemployment determination letter, etc.		
Insurance: insurance card(s)		

By signing below, I certify that the HPC staff may contact each employer listed and/or agencies to confirm my income. I will provide HPC with proof of income for the purpose of determining my discount. I will be asked to reapply for the program every 12 months or earlier if there is a change. I agree to inform HPC if there are changes to my income, household size, or insurance coverage. I understand that certain services and/or items cannot be discounted. I understand that HPC can only apply discounts to services provided by HPC. While HPC may have agreements with outside providers to offer services at a discount, I understand it will be my responsibility to directly apply for financial assistance for any services I have been referred to by HPC. I agree to pay my assigned slide level fee at the time of services. I understand that falsified documentation is subject to penalty and can disqualify me or family members from the program. I hereby certify that the information I provide is correct.

_____ _____

Applicant Signature **Date**

_____ _____

Guardian or Power of Attorney Signature **Date**

Revised 7/10/2018

INTERNAL OFFICE USE ONLY:

Account # _____ Discount Level Assigned: _____

Effective Date: _____ Application Approved By:_____