SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name: _____________________________________ Date of Birth: _________________ Account#: ________________

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>.

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

Name: (start with head of Household)	**Date of Birth:**	**Relationship:**	**Income:**	**HPC Acct#**
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	

Families larger than 10 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 _________ I have read and agree with the above statement.

Please select all that apply too all member of the household

Wages	**YES**	**NO**
Social Security	**YES**	**NO**
Cash Assistance	**YES**	**NO**
Business Income, self-employment	**YES**	**NO**
Unemployment, worker's compensation, disability, strike benefits, etc.	**YES**	**NO**
Child Support – Alimony	**YES**	**NO**
Educational grants, loans, and awards	**YES**	**NO**
Investment Properties/Rental Income	**YES**	**NO**

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

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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**

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INTERNAL OFFICE USE ONLY:

Account#: ______________________________

Combined Annual Income: _________________________

Discount Level Assigned: __________________________

Effective Date: __________________________

Application Approved By:___________________________