Five Rivers Health Centers

FIVE RIVERS HEALTH CENTERS

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Applicants Name _____ Today's Date _____

Address _____

City _____ State _____ Zip_____

Phone Number _____

It is policy of Five Rivers Health Centers to provide primary health care services to patients in need regardless of ability to pay. Discounts are offered to members of households with combined income of 200% and below of the Federal Poverty Level. To determine the percentage for which you qualify, please complete the following information and return to the front desk.

FAMILY:

Relationship	Include	Do Not Include	Number
Yourself			1
Your spouse	Include if you are legally married, regardless of sex. Include if you are legally married but living apart (for example, spouse is away on military duty, away on work, or away for some reason other than legally separated or divorced).	Do not include if you are legally separated or divorced. You do not need to claim your spouse if you are a victim of domestic abuse, domestic violence, or spousal abandonment.	
Child(ren)	Include number of tax dependent children. Include adopted and foster children, living with you that you can claim as a tax dependent. Include the number of children with whom you share custody if you can claim them as a tax dependent.	Do not include if a child is a non-dependent. Do not include if a child is unborn.	
Other dependents:	Include the number of parents you claim as tax dependents. Include the number of siblings and other relatives who you claim as dependents.	Do not include unmarried domestic partner unless you have a child together or you will claim them as a tax dependent. Do not include roommates.	
TOTAL NUMBER OF PEOPLE SUPPORTED BY THE FAMILY INCOME ABOVE:			

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INCOME:

Income	Verification	Amount
Wages, salaries, tips, etc.	Two (2) recent pay stubs. Most recent Form 1040 Line 22 Most recent W2 Box 1 Most recent form 1099 (for self-employment, significant business expenses should be reported on a form 1040 Schedule C)	
Alimony	Most recent month's check stubs	
Unemployment Compensation	Most recent month's check stub or itemized verification letter.	
Social Security Benefits	Most recent month's check stub or itemized verification letter.	
IRA or retirement plan distributions	Most recent month's check stub	
Interest, dividends, rental income	Most recent form 1040	
Business income	Most recent form 1040	
Capital gains	Most recent form 1040	
Other		
	TOTAL FAMILY INCOME: $	

List all household members below:

Name:	Date of Birth	Name:	Date of Birth
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Supporting documentation is required before Sliding Fee Scale Discount can be approved and approved discounts will be valid for up to twelve (12) months.

Acceptable forms include: copies of 2 recent checks/stubs, previous year W-2, previous year tax return, public assistance or social security check/stub or letter of Award, Medical Assistance or Dept. of Social Services Certification Letter, proof of Governmental Assistance, employer verification letter, or proof of zero income (letter of support that has been completed by the individual providing said support or a signed self-attestation).

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CERTIFICATION:

I certify the following to be true:

1) That the family size and income information listed is correct.
2) Documentation supporting my family's financial position is required before my discount can be approved, and that I must provide this information within **thirty (30) days** of the completion of this form.
3) I must update this information if my situation changes.
4) A new application must be completed at least every twelve (12) months.
5) I have received information explaining the program and I understand and agree to abide by the terms.
6) The discount program will only apply to services received at Five Rivers Health Centers. The sliding fee discount amount may vary depending on the services received.
7) The following services or equipment are not covered in this discount program.
    a. All services and equipment received or purchased outside of this clinic including
        i. Reference laboratory testing
        ii. Drugs
        iii. X-ray interpretation by a consulting radiologist
        iv. Other such services.
8) If I am a self-pay patient, I must pay a **minimum of $20** prior to receiving any health care services.
9) If an unpaid balance exists on my account after applying my discount percentage, **I agree to make payment arrangements and honor the terms.** If I am unable to make a payment in any given month, I must contact the Billing Office prior to the due date to discuss my need to modify my payment arrangement.
10) If I am unable to make a payment, I will contact Five Rivers Health Center's Billing Department at (937)734-6830.

_____

Patient Name (Please Print) Signature of Patient or Guarantor Date

WAIVER OF SLIDING FEE DISCOUNT

DO NOT sign below if you wish to be considered for a sliding fee discount.

I choose not to complete the Sliding Fee Application at this time. I am waiving my right to any discount for which I may otherwise be entitled. I understand that I will be responsible for full payment of all charges at the time of service.

_____

Patient Name (Please Print) Signature of Patient or Guarantor Date

FOR OFFICE USE ONLY:

ANNUAL GROSS INCOME CALCULATOR: Income received (frequency):	PER PAY PERIOD	GROSS ANNUAL INCOME
A. Weekly (each week):	$_____ x 52 =	$_____
B. Bi-Weekly (every two weeks):	$ _____ x 26 =	$_____
C. Semi-Monthly (twice a month):	$_____ x 24 =	$_____
D. Monthly (each month):	$_____ x 12 =	$_____

Documentation Provided (circle): YES NO

Application Approved (circle): YES NO

Application Processed by: _____

Processed on: _____

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