 Sliding Fee Discount Program

FOR OFFICE USE ONLY

\_\_\_ Recertification \_\_\_ New

Reviewed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Slide Level\_\_\_\_\_\_\_\_ Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Card Given \_\_\_ Card Sent

If applicable, Date Card Sent \_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Head of Family*\*\*)

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST EVERYBODY IN YOUR *FAMILY\**, EVEN IF THEY ARE NOT APPLYING FOR THE PROGRAM. LIST YOURSELF ON THE FIRST LINE. PLEASE PRINT.

(\**FAMILY:* Individuals of a household both traditional and non-traditional families that are tied together financially)

(\*\**HEAD OF FAMILY*: Individual responsible for making family decisions)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| FIRST and LAST NAME | IS THIS PERSON APPLYING? | | DATE OF BIRTH | | | SEX  M or F | RELATIONSHIP TO YOU | SOCIAL SECURITY NUMBER  (if available) | DOES THIS PERSON HAVE INSURANCE? | OFFICE USE  HEALTH RECORD # |
|  | Y | N | MONTH | DAY | YEAR |  |  |  |  |  |
|  |  |  |  |  |  |  | SELF |  |  |  |
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HAVE YOU APPLIED FOR MEDICAID or ANY OTHER INSURANCE? Medicaid: YES / NO (Circle One) Other Insurance: YES / NO (Circle One)

If applied, date you applied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where you applied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the application pending? YES / NO (Circle One)

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PLEASE CHECK ALL GROSS INCOME SOURCES FOR ALL *FAMILY* MEMBERS LISTED ON PAGE 1

(\**FAMILY:* Individuals of a household both traditional and non-traditional families that are tied together financially)

ALL INCOME VERIFICATION MUST BE CURRENT TO WITHIN 30 DAYS OF ORIGINAL APPLICATION

\_\_\_\_ Gross Wages/Salary \_\_\_\_ Self-Employment \_\_\_\_ Public Assistance \_\_\_\_ Social Security – SSI, SSD, or SS Retirement

\_\_\_\_ Pension/Retirement \_\_\_\_ Veterans’ Benefit \_\_\_\_ NYS Disability \_\_\_\_ Workers’ Compensation

\_\_\_\_ Unemployment \_\_\_\_ Child Support \_\_\_\_ Alimony \_\_\_\_ Interest Income

\_\_\_\_ Rental Income \_\_\_\_ Income Producing Property \_\_\_\_ Income from Boarder/Lodger \_\_\_\_

\_\_\_\_ Stock/Life Insurance Dividends \_\_\_\_ Other

PATIENT MUST INITIAL EACH LINE BELOW

\_\_\_\_\_\_\_I understand I MUST be an active patient at the Health Center, or enrolled in a Health Center Program.

\_\_\_\_\_\_\_ I understand the card(s) I am given are limited to the Health Center site, or Health Center Program, designated pharmacy, lab and x-ray providers.

\_\_\_\_\_\_\_ I understand the only charges paid for by the Sliding Fee Discount Program are office visits at the Health Center or the Health Center Program. This includes medical, dental, and on-site behavioral health services (if applicable).

\_\_\_\_\_\_\_ I understand I will receive a list of covered dental procedures and services offered at the Health Center or Health Center Program under this agreement.

\_\_\_\_\_\_\_ I understand that the Sliding Fee Discount Program *may* also cover charges for labs, x-rays, or prescriptions ordered by a Health Care Provider.

\_\_\_\_\_\_\_ I understand the following charges are not covered by this program: Emergency Room Visits, Ambulance charges, Outpatient/Ambulatory Surgery, Inpatient Hospital charges, Specialists Office Visits, Prescriptions written by the Specialist, and other charges not on list provided.

\_\_\_\_\_\_\_ I understand the Health Center Provider is not obligated to rewrite the prescription written by other community health providers.

\_\_\_\_\_\_\_ I understand I may be eligible for other programs such as Medicaid, Child Health Plus, EPIC, Prescription Assistance Program, etc., and I am encouraged to apply. The Sliding Fee Discount Program will take effect after applying for all other eligible programs.

\_\_\_\_\_\_\_ I understand that if there are any changes in my financial situation, I must notify the program enroller immediately and provide updated income information. I understand that if I fail to provide updated information I will lose my sliding fee discount benefits.

\_\_\_\_\_\_\_ I understand that this application is good for up to one year. Certain circumstances may result in termination.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

This is to certify that the information I have given regarding my present financial status and family composition is true and accurate, to the best of my knowledge. The coverage provided by the program has been explained to me. I have been given a letter that explains all services and where they can be obtained. I also understand that I must always present my card when obtaining services. The Authorization Period and Discount/Co-Pay amount have been explained to me and I understand both.

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Applicant/Head of Family Name (Please Print) Applicant/Head of Family Signature

If you filled this application out on behalf of another person, please print and sign your name, as well as provide your relationship to the applicant.

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Representative Name (Please Print) Representative Signature Representative Relationship to Applicant/Head of Family

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