mosaic health
Better happens together.

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			SOCIAL SECURITY NUMBER provide if available and only if applying for sliding fee program	LIST NAME OF HEALTH INSURANCE OR INDICATE YOU ARE UNINSURED	OFFICE USE HEALTH RECORD # N/A if not an active patient
	Y	N	MONTH	DAY	YEAR			

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)

PLEASE CHECK ALL GROSS INCOME SOURCES FOR ALL *FAMILY* MEMBERS LISTED ON PAGE 1
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 Programs. 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 Center Provider.

_____ I understand that I may receive a bill directly from LabCorp and understand that it is my responsibility to provide Mosaic Health a copy of this bill to be reviewed and paid for through the Sliding Fee Program.

_____ 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.

_____ 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.

_____ _____

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.

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

Name (Head of Family): _____ Date of Birth: _____ Health Record #: _____

INCOME SOURCE (MUST BE CURRENT)	Family Member	INCOME SOURCE – WEEKLY/BI-WEEKLY, ETC.	ANNUALIZED	ADJUSTED ANNUAL INCOME (GROSS INCOME – EARNED INCOME CREDIT - $90/MO - $1080 ANNUALLY)
Gross Wages/Salary (income before taxes) – last 4 stubs if paid weekly, last 2 stubs if paid bi or semi-monthly or statement from employer giving same information or DHHS Employers Statement		$	$	$
		$	$	$
		$	$	$
Self-Employment - last 2 years of Income Tax Forms or 1099s and verification of business expense		$	$	$
		$	$	$
		$	$	$
Pension/Retirement, Veterans' Benefit		$	$	$
		$	$	$
		$	$	$
NYS Disability, Workers' Compensation, Unemployment		$	$	$
		$	$	$
		$	$	$
Income Producing Property, Rental Income, Income from Boarder/Lodger		$	$	$
		$	$	$
		$	$	$
Stock/Life Insurance Dividends, Interest Income		$	$	$
		$	$	$
		$	$	$
Public Assistance, Social Security: SSI, SSD or SS Retirement		$	$	$
		$	$	$
		$	$	$
Child Support, Alimony		$	$	$
		$	$	$
		$	$	$
Other _____		$	$	$
		$	$	$
Other _____		$	$	$
		$	$	$
Other _____		$	$	$
		$	$	$
		TOTAL $	TOTAL $	TOTAL $

Prepared By: ____ Date: __________________________