

LITTLE RIVERS HEALTH CARE
Application for Sliding Fee Scale

APPLICANT NAME: _____ SS#: _____

ADDRESS: _____

DATE OF BIRTH: _____ TELEPHONE: _____

PLACE OF EMPLOYMENT: _____

PLEASE CIRCLE THE KIND OF INSURANCE YOU HAVE: Commercial Medicare Medicaid Self-Pay

ARE YOU CURRENTLY ELIGIBLE FOR MEDICAID?: Yes No Don't know

RELATED HOUSEHOLD MEMBERS OR THOSE FOR WHOM YOU HAVE LEGAL GUARDIANSHIP:

<u>NAME</u>	<u>DATE OF BIRTH</u>	<u>PATIENT AT LRHC</u>	
Spouse: _____	_____	YES	NO
Dependent (under age 18) _____	_____	YES	NO
Dependent (under age 18) _____	_____	YES	NO
Dependent (under age 18) _____	_____	YES	NO
Dependent (under age 18) _____	_____	YES	NO
TOTAL FAMILY SIZE : _____			

ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment				
Rent, interest, dividend, and other income				
Public Assistance i.e. welfare assistance, fuel assistance (excluding food stamps)				
TOTAL INCOME				

Proof of all sources of income required at time of application including copies of court orders if applicable.

Copy of 2010 Income Tax Return is required. If you are not legally required to file, see lists below.

Employed (one of the following)

- *Three most recent pay stubs
- *Written statement from employer stating hours/week, hourly wage, paid weekly or bi-weekly

Unemployed (All that apply)

- * Public Assistance check stub/copy
- *Social Security letter of award
- *Signed Declaration of No Income (clinic to provide)
- *Letter of reference from 501(c)(3) organization such as Church

(See Over)

ALLOWABLE DEDUCTIONS

SOURCE	SELF	SPOUSE	TOTAL
Court ordered or voluntary child support			
Court ordered or voluntary alimony			

** For voluntary child support or alimony, a letter from the recipient stating the amount and frequency of payment will suffice.

PLEASE NOTE:

- Co-pays and deductibles are eligible for the Sliding Fee Scale.
- Patients on the Sliding Fee Scale must re-apply annually in April as Federal Poverty Guidelines change.
- The discount will apply to all services received at our office but not services purchased from outside agencies i.e. lab testing, x-rays and entities other than LRHC.
- If there are special financial circumstances that you would like considered, please ask to speak with either the Office Manager or Care Coordinator.

I hereby certify that the above information is true and accurate to the best of my knowledge. I agree to provide any documentation requested and authorize the health center to verify all information provided. If any information I have given proves to be untrue, I understand that the health center may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant Signature

Date

FOR OFFICE USE ONLY:

CLINIC SITE SUBMITTING APPLICATION (circle):

WR

BR

EC