HRSA Sliding Fee Discount	2017 APPLICATION	

Last Name	First Name	Primary Phone	Date of Service
Mailing Address	City	State	Zip

Household Information				Insurance Status				Ethnicity	Race (please check one)					
Last Name	First Name	Relationship	DOB	None	Medicaid	Medicare	Private	Hispanic/ Latino? (Yes/No)	AK Native / Amer. Indian	White	Asian	Black/ African Amer.	Other Pacific Islander	More than one race
1														
2														
3														
4														
5														
6														
7														
8														

Please circle your household size and the income for that household size in the column(s) below.

Household size	Monthly Income								
	Level 1 $25 Nominal fee		Level 2 $50 Co-Pay		Level 3 $75 Co-Pay		Level 4 $100 Co-Pay		Greater than Level 4? (Check if Yes) ☐
1	Up to	$1,255	Up to	$1,883	Up to	$2,196	Up to	$2,510	
2		$1,691		$2,536		$2,959		$3,382	
3		$2,127		$3,190		$3,722		$4,253	
4		$2,563		$3,844		$4,484		$5,125	
5		$2,998		$4,498		$5,247		$5,997	
6		$3,434		$5,151		$6,010		$6,868	
7		$3,870		$5,805		$6,773		$7,740	
8		$4,306		$6,459		$7,535		$8,612	
Each Additional member add:		$436		$654		$763		$872	

Household is defined as all members of a family, related or unrelated, who are living together & pooling financial resources, if the arrangements are considered permanent & support greater than room and board is provided.

Return Application to clinic by (date):

Entered in: Cerner ☐ Emailed to: Sliding-discount@searhc.org ☐ Letter/card sent to patient ☐ Scanned into: EHR ☐

Please read the following statements, initial each one, and sign below to show you are in agreement:

_____ I have been advised that I must submit an application and provide proof of income to the clinic within 5 days to receive a discount for any future visits. If I do not provide proof of income within the 5 day period, I will be required to pay 100% of future costs.

_____ I understand that the sliding discount cannot be used for inpatient hospital stays. For any costs incurred while hospitalized, I will be fully responsible.

_____ I understand that the sliding discount may or may not apply to certain medications, and will not cover cosmetic procedures, or services provided at the clinic by independent specialist or outside providers.

_____ I agree to apply for any alternative resource programs for which I or my household members are eligible, such as Medicaid.

_____ I authorize SEARHC to verify information on my application. I understand that a deliberate misrepresentation is considered fraud, and is punishable by law.

_____ I authorize SEARHC to release information regarding my visits to my insurance company or other third party payer, and for payment to be made directly to SEARHC.

_____ I understand that the information provided here will be kept confidential except as noted above.

_____ I certify that the statements made on the application regarding my household, income, and all other items that pertain to eligibility are true and complete to the best of my knowledge.

____ ____

Signature of Applicant or Authorized Representative Date Signature of SEARHC Employee Receiving Application Date

FOR OFFICE USE ONLY

Verified By ____ Date Application Received ______________

SD Level: 1 2 3 4 Over Coverage Eligibility Date ________________ Comments:

____

Form revised 4.10.17