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 10 days to receive a discount for any future visits. If I do not provide proof of income within the 10 day period, I will be required to pay 100% of future costs.

_____ I understand that the HRSA Sliding Discount cannot be used for inpatient hospital stays. The SEARHC Financial Assistance Policy may be available to help cover costs associated with hospitalization. Eligibility criteria for the SEARHC Financial Assistance Policy will apply.

_____ I understand that the Sliding Discount does not cover prescriptions filled at a non-SEARHC pharmacy, and will not cover cosmetic procedures.

_____ 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: **0** **1** **2** **3** **4** Over Income Coverage Eligibility Date _________________ Comments:

____

Form revised 12.15.17