

Application received at:

(Clinic)

# 2019 Sliding Fee Discount

## APPLICATION



Last Name		First name		Primary Phone				Date of Service							
Mailing Address			City					State		Zip					
Household Information				Insurance Status				Ethni city	Race (please check one)						
Last Name		First Name	Relationship to applicant	DOB	None	Medicaid	Medicare	Private	Hispa nic/ 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										Check if income is Greater than Level 4: _____	
	Homeless: Level 0 (\$0 Co-Pay)	Level 1: \$25 Co-Pay	Level 2: \$50 Co-Pay Medical and BH Dental 75%	Level 3: \$75 Co-Pay Medical and BH Dental 50%	Level 4: \$100 Co-Pay Medical and BH Dental 25%							
1	Up to	\$1,300	Up to	\$1,950	Up to	\$2,275	Up to	\$2,600				
2		\$1,761		\$2,641		\$3,081		\$3,522				
3		\$2,222		\$3,333		\$3,888		\$4,443				
4		\$2,683		\$4,024		\$4,694		\$5,365				
5		\$3,143		\$4,715		\$5,501		\$6,287				
6		\$3,604		\$5,406		\$6,307		\$7,208				
7		\$4,065		\$6,098		\$7,114		\$8,130				
8		\$4,526		\$6,789		\$7,920		\$9,052				
Each Additional member add: \$461			\$691		\$806		\$922					

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

Entered in: Sharepoint

Letter/card sent to patient

Card 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 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:

\_\_\_\_\_