Peach Tree Healthcare

☐ PTC ☐ MIC ☐ PTYC ☐ LOC ☐ PTM ☐ PTNS ☐ YCDV ☐ SCDV ☐ PTPV ☐ PTCV

APPLICATION FOR SLIDING FEE ENROLLMENT

Please Print

ALL INFORMATION IS KEPT CONFIDENTIAL

Why do we need to know your household income?

- Some of our program budget comes from grant money. For most of these grants, income information from our patients is necessary to prove financial need in the communities we serve.
- These grants allow us to provide a much higher level of quality care and greater availability than we could otherwise.
- In order to obtain these grants and keep them, we need to provide demographic information, including financial resources of patients to prove that we are serving the people the grant money has been set aside for.

Applicant Name: ____

Social Security Number:______________________ Birth Date: ____________________

Address: ____

City: ______________________ State: __________ Zip Code: ______________

Home Phone Number: ________________ Work Phone Number: ____________________

Verification Needed: (one of the following)

☐ Two (2) most current pay stubs for bi-weekly, weekly or monthly pay from all employers for all members that have income. Pay stubs must be no older than 30 days.

☐ Last year's tax return ☐ Two (2) most current bank statement

☐ Letter from your employer stating how much you make and how many hours you work (on their letterhead) example: 5 days a week, 8 hours a day at $10.00 an hour

☐ Other: ______________________

I have been advised that I must provide proof of income to the clinic to receive a discount for my visit on ______________ and that if I do not do so, I will be required to pay 100% of the fee. I understand that the sliding fee discount does not apply to medications, cosmetic procedures, or services provided at the clinic by independent specialists or service providers. **I understand that a nominal fee is expected at the time of service**. The sliding fee discount is a resource of last resort. Applicant(s) who may qualify for other resources, such as Medi-Cal and Veteran's benefits, may apply for these programs, in compliance with the FQHC sliding fee policy. ***Services will not be denied based on ability to pay***.

______________________________ ______________________

Patient Signature Date

Rev. 01/22/2019

Peach Tree Healthcare

Definitions:

Household Members:

All members of a household who are related and/or pooling financial resources are counted as one family if the arrangements are considered permanent and support in addition to room and board is provided.

Income:

Income is defined as cash receipts received from all sources before taxes, including:

- Wages and Salaries
- Receipts from self-employment less operating expenses
- Payments from public assistance, social security, strike benefits, military allotments, disability, child support, government or private pensions, regular insurance or annuity payments. Income from dividends, interest, rents, royalties, estates or trusts.

Please complete the following information on yourself and all the family members.

First and Last Name	Relationship	Age	Date of Birth	Employer	Monthly Income
	Self				$
					$
					$
					$
					$
					$
				SECTION 1 SUBTOTAL	$

List Income that ALL family members are receiving:

Payment Source	Yes	No	Amount Per Month
Alimony			$
Child Support			$
Foster Care			$
Unemployment			$
Cash			$
Worker's Compensation			$
Social Security			$
Other Bonus			$
Retirement Bonus			$
Disability			$
Interest/Dividends			$
Rental Income			$
Other			$
	Section 2 Subtotal		$

Rev. 01/22/2019

The information provided on your application will be updated annually. If there is a change in your income, household size, and/or medical insurance please notify us immediately.

I give my authorization to verify information provided on this application. I authorize my insurance benefits to be paid directly to Peach Tree Healthcare, and I authorize the release of information regarding my office visits to my insurance company or other third party to see settlement of my account. I certify that the statements regarding the persons and income in my household are true and correct, and I agree to notify the clinic of changes in income, address, and number of household members. I understand that the information provided herein will be kept confidential except for the purpose noted above.

I understand and acknowledge that falsification of any information contained on this document constitutes fraud and is punishable by either a fine or imprisonment, or both.

____ _______________________________

Patient Signature Date

Customer Service Specialist Name:______________________________ **Date** _____________________