MIDTOWN HEALTH CENTER

Sliding Fee Discount Application

***Please download and complete all pages. Once finished, Email to*: intake@midtownhealthne.org**

It is the policy of Midtown Health Center to provide essential health services regardless of a person's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information to determine if you or members of your family are eligible for a discount. This discount will apply to services received at Midtown except for those elective procedures and treatment-related supplies/equipment and those services or equipment that are purchased from the outside, including laboratory testing. Once you are approved for the sliding fee, your eligibility is good for one year as long as your income does not change.

Applicant Information:

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____

Home Address _____ _____ _____ _____

Street *City* *ST* *Zip Code*

Place of Employment: _____

List spouse/partner, dependents, and anyone else cared for by a household member or shares in the financial responsibility of the household:

Name		**Date of Birth**
Spouse/Partner:		
Household Member:		
Household Member:		
Household Member:		
Household Member:		
Household Member:		
Household Member:		
Household Member:		
Household Member:		

List Annual Household Income:

				Office Use Only	
Source	**Self**	**Spouse**	**Other HH Member**	***Verified***	***Document***
Earnings (wages, salaries, self-employment income, tips)					
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance (TANF and other cash welfare), veterans' payments, survivor benefits					
Child support and alimony					
Pension or retirement income					
Interest income, dividend income, rents, royalties, income from estates, trusts, educational assistance (government and non-government)					
Income from outside the household					
Other sources					

NOTE: Copies of tax returns, pay stubs, or other information verifying income will be required before a discount is approved. See page 3, Income Verification Documents Checklist.

I certify that I understand the information provided to me about the sliding fee discount and I understand that if I am providing false information, discounts will be revoked and that I am responsible for the full balance of the account(s) payable immediately. I also agree to provide the verification documents and understand that if they are not returned within 14 days, all services will be billed at full price.

Name (Print):	**Date:**
Signature:	

(*Sign at Clinic)*

Office Use Only

Patient Name:	***Amount Approved:***
Approved by:	***Date Approved:***

Income Verification Documents Checklist

Patient Name:	***Date of Birth:***	***Date documents are due. <u>If past due, services will be billed at full price</u>.***
Guarantor Name:	***Relationship to Patient:***	

Provide any the following documents to verify the household's income:
If you are unable to include any of the listed documents in your email, please bring a hard copy to your next visit.

	Two (2) most recent pay stubs
	Most recent year's tax return, preferably including W-2s as well
	Letter from Department of Labor showing unemployment benefits
	Notice from Veteran's Administration showing current veteran's or survivor benefits
	Most recent notice from Social Security Administration showing current SSA or SSI amounts
	Printout from court showing current child support and/or alimony payments
	Proof of pension/retirement/trust payments
	Letter from current family residence/treatment center/shelter that is giving assistance to the patient
	Other household income as applicable (TANF, Worker's Compensation, educational assistance, etc.)
	Self-employment income (Most recent tax return/ Completed ledgers/Printout of financial from QuickBooks or comparable electronic bookkeeping system)
Comments:	

Patient Signature: *(Sign at Clinic)*	**Date:**
Midtown Staff Member:	**Date:**