

Important

We are pleased to inform you that you may be eligible to apply for a discount on your medical or dental services today based on your income. To ensure that we can offer this service to every eligible client, we must make sure that someone not eligible, who can afford the services, is not receiving a fraudulent discount. With this in mind, we are asking you to fill out and sign the application below. Please tell us about your HOUSEHOLD Income. Find the Household Size in the column on the left, then go across that line and circle your annual household gross (before taxes/deductions) income range in the same line.

Family Size

Size	A-B	C-D	E-F	G-H	I-J	K
1	\$10,830	\$10831 - \$13538	\$13539 - \$16245	\$16246 - \$18953	\$18954 - \$21659	\$21660
2	\$14,570	\$14571 - \$18213	\$18214 - \$21855	\$21856 - \$25498	\$25499 - \$29139	\$29140
3	\$18,310	\$18311 - \$22888	\$22889 - \$27465	\$27466 - \$32043	\$32044 - \$36619	\$36620
4	\$22,050	\$22051 - \$27563	\$27564 - \$33075	\$33076 - \$38588	\$38589 - \$44099	\$44100
5	\$25,790	\$25791 - \$32238	\$32239 - \$38685	\$38686 - \$45133	\$45134 - \$51579	\$51580
6	\$29,530	\$29531 - \$36913	\$36914 - \$44295	\$44296 - \$51678	\$51679 - \$59059	\$59060
7	\$33,270	\$33271 - \$41588	\$41589 - \$49905	\$49906 - \$58223	\$58224 - \$66539	\$66540
8	\$37,010	\$37011 - \$46263	\$46264 - \$55515	\$55516 - \$64768	\$64769 - \$74019	\$74020

Each additional family member, add \$3740.

If you circled an income in column K, we thank you for taking the time to complete this form. I am sorry, you are not eligible for the program. Please give this paper to the receptionist.

Dear Patient:

We are pleased to be able to allow you a discount for your medical services because we believe it is essential that health care be affordable. To ensure that we can offer this service to every client, we must make sure that someone not eligible, who can afford the services, is not receiving a fraudulent discount. With this in mind, we are asking you to fill out and sign the application below.

NAME: _____ ADDRESS: _____ CITY/STATE/ZIP: _____ AGE: _____ PHONE: _____

NAME OF DEPENDENT CHILDREN _____

AND SPOUSE LIVING IN THE HOME: _____

SLIDING FEE: _____ MEDICAL _____ DENTAL _____ PODIATRY _____ OPTOMETRY _____

REFERRING PROVIDER: _____ DATE: _____

INCOME: Jobs, social security, child support, SSI, interest on bank accounts, pensions, retirement funds, veteran funds, medicaid general assistance, rentals or employment.

WEEKLY _____ MONTHLY _____ ANNUAL _____ x52 _____ x12 _____

ANY ADDITIONAL INCOME OF ANY KIND: _____

TOTAL INCOME: _____ VERIFIED BY: _____ PHONE CALL _____ LETTER _____

WAGE STUB _____ COPY OF CHECK _____ IRS FORM _____ OTHER _____

(DATE) (SIGNATURE OF AUTHORIZED STAFF MEMBER)

NUMBER OF DEPENDENTS ON ABOVE INCOME: _____

The above information is true and correct. I understand I am paying the minimal fee or the discounted _____ % of my bill. I will report any income changes to Community Health & Emergency Services, Inc.

I understand that verification of income should be presented prior to my next visit or within ten (10) days, whichever date is first.

(DATE) (PATIENT SIGNATURE) (WITNESS)

For Agency Use Only

_____ Card Issued _____ Date Verified _____ % Medical _____ Need Verification

_____ Number in Household _____ % Dental _____ Denied/Not Eligible