Carolina Family Health Centers, Inc.

Carolina Family Dental Center • Freedom Hill Community Health Center • Harvest Family Health Center • Wilson Community Health Center

Sliding Fee Discount Program Application

DATE: _____

PATIENT ID#_____

SECTION I: PATIENT INFORMATION

NAME_____ DOB____/____/___ Patient ID#_____

ADDRESS_____

PHONE_____

Do you have insurance? Yes _____ No _____
Including, but not limited to: Medicaid, Medicare, BC/BS, United Healthcare, MedCost, VA, ACA, and any other private insurance.

SECTION II: FAMILY INFORMATION

List members who are part of the patient's household beginning with the Guarantor (person responsible for payment of the patient's account). If any family member is covered by health insurance, Medicaid or Medicare, describe insurance coverage below. Family members are persons related by birth, marriage, or adoption who reside together. Unrelated individuals, even in the same house, are considered to be separate families.

NAME	RELATIONSHIP	AGE	INSURANCE COVERAGE
_____ *GUARANTOR*	_____	_____	_____
_____ *PATIENT*	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

STAFF: A copy of the front and back of the patient's or guarantor's insurance card must be attached.

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SECTION III: INCOME INFORMATION

Proof of income is required. Income is defined as total annual earnings, before taxes, from all sources: including salaries, public assistance, unemployment, retirement payments, social security, child support, alimony and earnings from self-employment (your own business or farm). Income does not include gifts, assets from the sale of property or non-cash benefits such as Medicaid, food stamps, public housing, etc.

List all working family members:

Family Member Name ____ Employer Name ______________________________

Hourly Pay $__________ x Hours/Week___________ = Weekly Gross $___________ x 52 weeks = Gross Annual $_____________

Does this family member work a second and/or a part-time job? ___________ If Yes, complete information below
YES/NO

Family Member Name ____ Employer Name ______________________________

Hourly Pay $__________ x Hours/Week___________ = Weekly Gross $___________ x 52 weeks = Gross Annual $_____________

Does this family member work a second and/or a part-time job? ___________ If Yes, complete information below
YES/NO

Family Member Name ____ Employer Name ______________________________

Hourly Pay $__________ x Hours/Week___________ = Weekly Gross $___________ x 52 weeks = Gross Annual $_____________

Does this family member work a second and/or a part-time job? ___________ If Yes, complete information below
YES/NO

Does any family member receive Social Security or Disability? Yes_____ No _______
Family Member Name _____________________________ Monthly Check $____________ x 12 = Gross Annual $______________
Family Member Name _____________________________ Monthly Check $____________ x 12 = Gross Annual $______________

Does any family member receive Retirement or Pension Checks? Yes_____ No _______
Family Member Name _____________________________ Monthly Check $____________ x 12 = Gross Annual $______________
Family Member Name _____________________________ Monthly Check $____________ x 12 = Gross Annual $______________

Does any family member receive Child Support and/or Alimony? Yes_____ No _______
Family Member Name _____________________________ Monthly Check $____________ x 12 = Gross Annual $______________

Does any family member receive ADC or Welfare Assistance? Yes_____ No _______
Family Member Name _____________________________ Monthly Check $____________ x 12 = Gross Annual $______________
Does your family have any other source of income? Yes ______ (Describe Below) No _________
____ Gross Annual $______________

TOTAL NUMBER OF FAMILY MEMBERS SUPPORTED BY THIS INCOME:______________________

TOTAL ANNUAL INCOME $_____________________ SLIDING SCALE DESIGNATION __________ %

If patient does not have a source of income, have the patient complete the "No Source of Income" section of Application Attachment.

If patient is unable to provide proof of income because the current employer does not provide, have the patient complete "Self-Declaration of Income" section of Application Attachment.

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SECTION IV: PATIENT ATTESTATION

I certify that the information provided is true and accurate. I have reported all sources of income being received to support my family. I understand that legal action can and will be taken against me if I have not made full disclosure regarding my financial status. I further agree to notify Carolina Family Health Centers, Inc.(CFHC, Inc.) any time my financial status or family size changes.

I certify that the address in Section I of this application is my actual physical address on the date I completed this application.

I agree to notify CFHC, Inc. any time my insurance status changes. I understand that CFHC, Inc. bills my insurance company as a courtesy to its patients and that it is my responsibility to perform any necessary follow up with my insurance company or to request assistance from CFHC, Inc. staff. I also understand and agree that all charges left unpaid by the insurance company are my responsibility.

Additionally, my signature certifies that I grant permission to patient assistance programs, North Carolina AIDS Care Program or its designees to review my eligibility records for audit purposes.

*Signature of Guarantor*_____ Date _____

*Signature of Patient*_____ Date _____

As an employee of CFHC, Inc., I certify that the information in the application is an accurate representation of the information the PATIENT reported and completed to the best of my ability.

Signature of CFHC, Inc. Staff _____ Date _____