Patient Demographics

Sliding Fee Discount Program

Name (Head of Household): _____ Phone #: _____ Date: _____

Address_____

LIST EVERYBODY IN YOUR *FAMILY**, EVEN IF THEY ARE NOT APPLYING FOR THE PROGRAM. LIST YOURSELF ON THE FIRST LINE. PLEASE PRINT.
(**FAMILY:* Individuals of a household both traditional and non-traditional families that are tied together financially)

LAST NAME, FIRST NAME	IS THIS PERSON APPLYING?		DATE OF BIRTH			SEX M or F	RELATIONSHIP TO YOU	SOCIAL SECURITY NUMBER (if available)	DOES THIS PERSON HAVE INSURANCE?	**OFFICE USE** **RPCN/ProAct ID#:**
	Y	N	MONTH	DAY	YEAR					*Location (R, U, N, UD) – MRN with leading zeros*
							SELF			

HAVE YOU APPLIED FOR MEDICAID or ANY OTHER INSURANCE? Medicaid: YES / NO (Circle One) Other Insurance: YES / NO (Circle One)

If applied, date you applied _____Where you applied _____ Is the application pending? YES / NO (Circle One)

PLEASE LIST ALL GROSS INCOME SOURCES & AMOUNTS FOR ALL *FAMILY* MEMBERS LISTED ABOVE – All income verification must be current to within 30 days of original application.

INCOME SOURCE EXAMPLES:	**WHO & KIND OF INCOME**	**INCOME:** **Weekly (x4.333333)** **Bi-Weekly (x2.16666)**	**INCOME: Monthly**	**INCOME: Annual**
Gross Wages/Salary paystubs to cover last 4 weeks or statement from employer giving some information or DHHS Employer Statement				
Self Employed – complete Self Employment (3) Month Breakdown form				
Pension/Retirement – Veterans' Benefit – Unemployment – Workers' Compensation				
NYS Disability – Public Assistance – Rental Income – Income from Boarder/Lodger				
Income Producing Property – Stock(s) – Life Ins. Dividends – Interest Income				
Child Support – Alimony – Loans – Social Security (SSI, SSD, or SS Retirement)				
Other:				
				TOTAL:

PATIENT MUST INITIAL EACH LINE BELOW

_____ I understand I MUST be an active patient at the RRH Health Center

_____ I understand the card(s) I am given are limited to the RRH Health Center site, designated pharmacy, lab and x-ray providers.

_____ I understand the only charges paid for by the Sliding Fee Discount Program are office visits at the RRH Health Center. This includes medical, labs, X-Rays, and prescriptions written by my RRH Health Center Primary Care Physician.

_____ I understand I will receive a list of covered dental procedures and services offered at the RRH Health Center under this agreement.

_____ I understand that the Sliding Fee Discount Program *may* also cover charges for labs, x-rays, or prescriptions ordered by a RRH Health Care Provider.

_____ I understand the following charges are not covered by this program: Emergency Room Visits, Ambulance charges, Outpatient/Ambulatory Surgery, Inpatient Hospital charges, Specialists Office Visits, Prescriptions written by the Specialist, and other charges not on list provided.

_____ I understand the RRH Health Center Provider is not obligated to rewrite the prescription written by other community health providers.

_____ I understand that if there are any changes in my financial situation, I must notify the program enroller immediately and provide updated income information. I understand that if I fail to provide updated information I will lose my sliding fee discount benefits.

_____ I understand that this application is good for up to one year. Certain circumstances may result in termination.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

This is to certify that the information I have given regarding my present financial status and family composition is true and accurate, to the best of my knowledge. The coverage provided by the program has been explained to me. I have been given a letter that explains all services and where they can be obtained. I also understand that I must always present my card when obtaining services. The Authorization Period and Discount/Co-Pay amount have been explained to me and I understand both.

☐ Patient/legal representative's preferred language: _____ Interpreted by: _____

_____ _____ _____

Applicant/Head of Family Name (Please Print) | Applicant/Head of Family Signature | Date

If you filled this application out on behalf of another person, please print and sign your name, as well as provide your relationship to the applicant.

_____ _____ _____

Representative Name (Please Print) | Representative Signature | Representative Relationship to Applicant/Head of Family

FOR OFFICE USE ONLY

_____ Recertification _____ New Reviewed by _____ Date: _____ Time: _____

Slide Level: _____ Card Given: _____ Authorization Period: _____ Coverage added to CareConnect: _____