

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 and have shared financial responsibility. Unrelated individuals, even in the same house, are considered to be separate families.

| NAME | RELATIONSHIP | AGE | INSURANCE COVERAGE |
|---------------------------|--------------|-------|--------------------|
| _____ <i>GUARANTOR</i> | _____ | _____ | _____ |
| _____ <i>PATIENT</i> | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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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Sliding Fee Discount Program Application - Attachment

DATE: _____

PATIENT ID#_____

| |
|--|
| 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* _____

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DATE: _____

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NO SOURCE OF INCOME

I, _____ (Patient Name), currently do not have any source of income and I do not expect to receive any income until _____ (Date).

My current living arrangements and support to prevent homelessness include:

- ☐ Living with a family member/friend _____ (Family/Friend Name)
The friend or family member does not provide any financial support and does not wish to be included in any of my personal affairs.
- ☐ Living in a shelter _____ (Shelter Name)

SELF DECLARATION OF INCOME

I, _____ (Patient name), attest that my current monthly income is

\$_____.

I am unable to provide Carolina Family Health Centers, Inc. with a written copy of my proof of income because:

- ☐ My employer does not provide proof of income.
- ☐ I have experienced theft, loss, or damage that prevents me from providing proof of income.
- ☐ I have recently escaped from a high-risk situation that prevents me from providing proof of income.
- ☐ Other: _____

30 DAY GRACE PERIOD

I, _____ (Patient name), am unable to provide supporting documentation at the time of this application. I understand that I can declare the household income under a grace period and provide supporting income within 30 days of application.

My current monthly household income is: \$_____.

This statement is my declaration to Carolina Family Health Centers, Inc. that I do not have any source of income, have self-declared income for the above-stated reason(s), or am utilizing the 30 day grace period. I understand that if my income situation changes I am responsible for notifying this facility as soon as possible.

Patient Signature

Date

Witness Signature

Date