Blessing Community Health Center
SLIDING FEE DISCOUNT PROGRAM
APPLICATION

It is Blessing Community Health Center's policy to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at the center but not those services which are purchased from outside, such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and similar services. In the hope that your economic health improves, discounts apply only to current, not future services. This form must be completed annually and/or if there are any changes. Please inquire at the front desk if you have questions.

*Number of related persons living in your household: _____

Applicant Name:			
ADDRESS:		**CITY:**	**ZIP:**
HOME PHONE:	**CELL PHONE:**		

PLEASE LIST SELF, SPOUSE, AND DEPENDENTS UNDER THE AGE OF 18.

NAME		Date of Birth	NAME		Date of Birth
SELF			**DEPENDENT #3**		
SPOUSE			**DEPENDENT #4**		
DEPENDENT #1			**DEPENDENT #5**		
DEPENDENT #2			**DEPENDENT #6**		

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Social Security, Pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business, self-employment, and dependents				
Rent, interest, dividend, and other income				
TOTAL INCOME				

Note: Include income from all related persons in household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, Veteran's payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print): _____ Signature/Date: _____

OFFICE USE ONLY

Patient Name: _____ Discount: _____

Date of Service: _____ Approved by:

_____

Blessing Community Health Center
SLIDING FEE DISCOUNT PROGRAM
SELF-DECLARATION OF INCOME

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

Please check and complete the following information:

I, _____, declare that I have been working and receiving

cash payments in the amount of $ _____ per (check one) ____ day; ____ week;

____ bi-weekly; ____ monthly.

Name of Employer: _____

_____ I declare that I have no check stubs or other documentation to prove my earnings.

_____ I declare that I am unemployed and do not have any income at this time.

I understand that any falsification or failure to report any income or changes in income may result in my being ineligible for the sliding fee scale adjustment to my charges for services.

SIGNATURE: _____ DATE: _____

For staff use only

Witness:

I witness that this patient has no documentation for the proof of income:

Print Name: _____ Date: _____

Signature of Witness _____

SLIDING FEE DISCOUNT PROGRAM
Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receivethe **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box foryou.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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