Attachment B

APPALACHIAN MOUNTAIN HEALTH

SLIDING FEE APPLICATION

AMH provides healthcare services to the community regardless of a patient's ability to pay for essential healthcare services provided. Discounts are offered based on household annual income and size. Please provide the information below and return this form to the front desk staff to determine if you or members of your household are eligible for a discount.

The discount will apply to healthcare services received at this clinic at the time of service, but will not cover those services which are purchased from outside our facility. For example, laboratory testing is not offered at our clinic, certain medications, x-ray interpretation by a consulting radiologist, etc.

Discounts are applied for one year. In the hopes that your financial situation improves, we ask that you notify the clinic as soon as possible to update your information. This form must be updated each year to continue to receive the discount. If you have questions, please speak with a front desk staff.

PATIENT NAME: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Annual Household Income: Are you the head of the household? Yes,❒ No❒ Number of persons living in your household: _

HOUSEHOLD MEMBER	HOUSEHOLD INCOME (complete one column)			
	Annual	Monthly	Bi-Weekly	Weekly
SELF				
SPOUSE				
DEPENDENT CHILDREN UNDER THE AGE OF 18				
TOTAL				

Please list all household members:

Name	Date of Birth	Relationship	Social Security Number
Self			
Spouse			
Dependent			
Dependent			
Dependent			
Dependent			

NOTE: *Copies of tax returns, pay stubs, or other information verifying your income may be required before a discount is approved.*

I certify that my family size and income shown above are correct.

_____ _____

Patient's Signature Today's Date

Office Use Only

Verify the patient's address, DOB, SSN, as well as their employment status listed on the patient registration form and/or in the patient's account.

ID Provided: Yes❒ No❒ Insurance Card Provided: Yes❒ No❒ Income Verified: Yes❒ No❒

Approved Discount Level: (circle one) A B C D E Amount Paid $_____

AMH Staff Member Signature:_____ Approval Date:_____

Attachment C

SELF-DECLARATION/ATTESTATION OF INCOME

Eligibility for Federal Poverty Sliding Fee Adjustment

Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to willfully make false statements or misrepresent facts to any agency or representative of the U.S. Government under its jurisdiction.

Patient Name: _____ Date: _____

Patient Chart #: _____

Responsible Party (Parent/Guardian): _____

REASON FOR COMPLETING THIS FORM:

- ❒ Self-declaring annual household income and family size
- ❒ Currently not working
- ❒ Not receiving any type of benefits or income (e.g., homeless)

_____ I further declare that no other family member is receiving income/benefits that would pay for services. I understand that when I or any other family member begins receiving any type of benefit, I must report this benefit to Appalachian Mountain Community Health Centers (AMH).

_____ I do NOT have health insurance that will pay for my services. If it is verified later by an AMH employee that I do have health insurance, AMH reserves the right to bill the Insurance Company for all covered dates of service.

_____ Annual Gross Income: $_____

_____ Family Size: _____

Patients will not be able to re-apply for participation in the Sliding Fee Discount program until they bring in the required proof of income and family-size documentation. Patients will be charged for 100% of the healthcare services and/or pharmacy prescriptions on their next visit if they do not bring in the required documents after the 30-day grace period.

PATIENT SIGNATURE _____ DATE _____

OFFICE USE ONLY

AMH Staff (Accepted by): _____ Date: _____ Signature: _____

Supervisor (Verified & Approved by): _____ Date: _____ Signature: _____