MT ROSE HEALTH CENTER

Discounted /Sliding Fee Application

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

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This form must be completed for each visit. Please inquire at the front desk if you have questions.

Number of related persons living in your household: _____

Total household income (complete one column)

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi Weekly
Self			
Spouse			
Dependent Children under age 18			
Total			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran payments, net business or self- employment, alimony, child support, military, unemployment, and public aid.

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 _____

Mt Rose Health Center
Family Assistance Plan Application

Name of Head of Household			Place of Employment	
Street	City	State	Zip	Phone
Health Insurance Plan		Social Security number		

Please list spouse and dependents under age 18

Name		Date of Birth	Name		Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

Annual Household Income

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				

Verification Checklist (attach copies)	Yes	No

Identification/Address: Driver's License, birth certificate, employment ID, social security card or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection		

I certify that the information shown above is correct and understand verification is required for approval.

_____ _____

Name (Print) Signature/Date

Office Use Only

Pay class approved: _____ Effective date: _____

Approved by: _____ Expiration date: _____

REVISED: APRIL 1,2017