RGH Clinic

42121 US Hwy 70
PO Box 299
Portales, NM 88130
P. 575.356.6652
F. 575.359.6827
www.MyRGH.org

SLIDING FEE SCALE CHECKLIST

The following information must be submitted at the time of the appointment to avoid delay in the qualification process.

____ Proof of Income (one of the following) for <u>all household members 18 years and above</u>

- Tax Return
- Month's Worth of Income
  - Need paycheck stubs for all working members of the household
- Wage Statement

____ Picture I.D.

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APPLICATION OF SUBSIDIZED SERVICES

Head of Household Information			
Name:		Birth Date:	
SSN:	Phone:		
Address:			
City:	ST:	Zip	
Race (please circle): White Hispanic African American Asian Other Pacifier Islander More than one race American Indian Alaskan Native Native Hawaiian Other			
Employer:			
Work Phone:	City:	ST:	

Household Members		
Name	Birth Date	Relationship to Applicant

Source of Income				
	Amount	Bi-Weekly	Monthly	Annual
Salaries/Wages (Self)				
Salaries/Wages (Spouse)				
Pension Plan /IRA				
Workman's Comp				
Social Security (Self / Spouse)				
Social Security (Children)				
Supplement Security Income				
Child Support / Alimony				
Documented Tip Income				
Unemployment Benefits				
Public Assist / Food Stamps				

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I understand that Roosevelt General Hospital Physicians Clinic receives funds under Section 330 of the Public Health Service Act to help subsidize the cost of services for patients whose documented gross income is below 200% of the current Federal poverty level for that patient's family size.

I understand that these subsidized services are only for patients who meet one or more of the eligibility criteria and that federal regulation require that Roosevelt General Hospital Physicians Clinic at least annually certify my eligibility for subsidized services and document this certification in my permanent record.

I understand that if I quality for subsidized services, they will be provided to me at a discount so long as I continue to qualify. I agree to inform Roosevelt General Hospital Physicians Clinic of substantial change in my economic status which could prevent me from being eligible for the subsidy. I also agree to provide updated proof of income at future visits upon request.

I understand that federal regulations require Roosevelt General Hospital Physicians Clinic to collect at least a nominal fee for services rendered and that I am expected to pay a minimum charge at each visit.

I understand that I am responsible for all charges and that Roosevelt General Hospital Physicians Clinic may engage a collection agency to collect from me if I fail to make timely payments. Knowing these limitations, I hereby request subsidized medical services at Roosevelt General Hospital Physicians Clinic based on the following criteria:

Your documented annual income is $_____.
Your documented family size is: _____.
Therefore you qualify for Tier: _____.

I hereby certify that the income and family composition information supplied on the application is true and correct to the best of my knowledge. I understand this document will be maintained in my permanent record and that falsification of information may constitute a federal offense.

CONSENT FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

I hereby authorize any medical or surgical care which is considered by the staff of Roosevelt General Hospital Physicians Clinic and their contracting physicians to be in my, or my family's best interest, and authorize the release of any information required in the course of registration, examination, or treatment.

Signature: _____ Date: _____