**Sliding Fee Scale Checklist**

The following information must be submitted at the time of the

appointment to avoid delay in qualification process.

\_\_\_\_ **Proof of Income** (one of the following) for **all household members 18 years and above**

--Must have proof of income for each and every person over 18 years in household

• Tax Return for latest year

-or- • One full, consecutive Month’s Worth of Income

Need paycheck stubs for each and every working members of the household

-or- • Statement of Social Security Income

Must have last year’s income

(retrieved from the Social Security Office in Clovis or

By going to [www.ssa.gov](http://www.ssa.gov) to request your contributions)

\_\_\_\_ **Picture I.D.**

**\*\*IMPORTANT NOTE\*\***

The sliding fee scale application must be submitted to RGH Clinic within 3 days of hospital or clinic discharge. Failure to return a completed application with proof of income will result full patient responsibility for charges incurred.

*Staff use only:*

*Date seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date to be returned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Returned Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ QUALIFIED FOR LEVEL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*In PM □ Letter Sent □ EHR to LeNeva □*

*NAME ON SFS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**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/Others) |  |  |  |  |
| Salaries/Wages (Others) |  |  |  |  |
| Pension Plan /IRA |  |  |  |  |
| Workman’s Comp |  |  |  |  |
| Social Security (Self ) |  |  |  |  |
| Social Security (Spouse/Others) |  |  |  |  |
| Supplement Security Income |  |  |  |  |
| Child Support / Alimony |  |  |  |  |
| Documented Tip Income |  |  |  |  |
| Unemployment Benefits |  |  |  |  |
| Public Assist / Food Stamps |  |  |  |  |

I understand that RGH 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 RGH 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 RGH 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 RGH 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:**

*Staff Use Only:*

*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.

***X*** Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_