Rural Health Group Income Assessment

Why am I asked about my income?

Rural Health Group is a federally qualified health center (FQHC) and asks ALL patients about housing, veteran status, household size and income. RHG uses the household size and income to determine eligibility for the sliding fee discount program. These questions are asked regardless of insurance status. ***You can still qualify for a sliding fee discount if you have medical insurance***. We screen you for programs you may be eligible for and give you information to help you apply.

Patient Information

Patient Name:	**Date of Birth:**
If patient is under 18, Parent/Legal Guardian Name:	*Relationship:*
Please check your housing/living situation: ☐ Living in my own home ☐ Homeless ☐ Living with relatives/friends ☐ Shelter/Transitional housing	Are you a veteran? ☐ Yes ☐ No

Do you have medical insurance? ☐ No ☐ Yes **Health Insurance Name:** _____

(If you have insurance, we will bill your insurance carrier and apply the discount to any balance due for co-pays and deductibles.)

How many people are in your family/household? Total _____

My household earns

☐ $0-$24,980/yr ☐ $24,981-$33,820/yr ☐ $33,821-$42,660/yr
☐ $42,661-$51,500/yr ☐ $51,501-$60,340/yr ☐ $60,341-$69,180/yr
☐ $69,181-$78,020/yr ☐ $78,021-$86,860/yr ☐ over $86,861
☐ ***I do not wish to disclose my household income.***

Certification

By signing this I certify the following:

- Rural Health Group's sliding fee discount program has been explained to me.
- I have been offered an opportunity to apply for the discount program.
- I do not wish to apply at this time ***or*** I am ineligible for the program.
- I understand that I can be reassessed for the program if my income or household size changes ***or*** I decide to complete the application process by providing my household size and proof of income.

_____ _____/_____/_____

Signature **Date**

(Patient or legal guardian/closest relative/authorized representative, if the patient cannot sign)

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Income & Family Size:

☐ Meets guidelines ☐ Does not meet guidelines ☐ Did not disclose

Sliding Fee Application:

☐ Application Initiated ☐ Application offered but patient does not wish to apply at this time

RHG Staff Signature: _____ Date: _____