Rural Health Group Sliding Fee Discount Program Application

In order to apply for discounted services at Rural Health Group we need to know a little about your family and income. This information is only used to calculate your discount and is *kept confidential*.

Applicant Information

Patient Name:	Date of Birth:
If patient is under 18, Parent/Legal Guardian Name:	*Relationship:*

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

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

Are you prepared to pay for your visit in full today? ☐ No ☐ Yes

Are you currently employed? ☐ No ☐ Yes

Household Information

Please list ALL MEMBERS of your household. Include those who contribute to the household income and all persons for whom you are financially responsible for or those you can claim on your taxes. (Additional space for household members is located on the reverse.)

If you have children under the age of 18, Rural Health Group encourages you to apply for Medicaid as the best option for you and your family if you are unable to pay for medical services.

How many people are in your family? # Children: _____ # Adults: _____ = Total _____

Name	Age	Relationship to Patient

Income Information

Please give an estimate of your household income – include all members of your family. (Income is calculated before taxes.)

My household earns $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly Please check which item(s) you will be providing as proof of income:

☐ Most recent paystub ☐ W-2, 1099 form(s), 1040 ☐ Bank statement

☐ IRS 4506-t Tax Form ☐ Letter from employer ☐ Award letter or benefit statement

Note: If you are not able to provide one of the above as proof of income, or if you have NO source of income, please complete the section on the reverse.

Certification

By signing this I certify that all of this information is true.

_____ _____/_____/_____

Signature Date

(Patient or legal guardian/closest relative/authorized representative, if the patient cannot sign) *(Eligibility expires 12 months from date)*

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Zero Income/No Proof of Income

If you are unable to provide PROOF OF INCOME, have NO INCOME, or have a HARDSHIP, please give a brief description of your current situation:

☐ I am unable to provide income ☐ I have no income ☐ I am having a hardship

PATIENT STATEMENT REQUIRED:

Certification

By signing this I certify that all of this information is true.

_____ _____/_____/_____

Signature Date

(Patient or legal guardian/closest relative/authorized representative, if the patient cannot sign) *(Eligibility expires 12 months from date)*

Household Information, Cont.

Name	Age	Relationship to Patient

For Office Use Only

RHG Staff Signature: _____ Date: _____

☐ **Conditionally** Approved - 30 days (Need POI) ☐ Approved - 1 year ☐ Denied

☐ Routed to RHG Leadership or Designee for hardship/denial review

Reviewer's Notes: _____

_____

_____

Application Validated by: _____ Date: _____

Denial Confirmed by: _____ Date: _____