OZARKS COMMUNITY HEALTH CENTER SLIDING FEE SCALE APPLICATION

DATE: _____

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____

DATE OF BIRTH: _____ SS# _____

Patient Reminder List:

- ☐ **Completed Sliding Fee application**
- ☐ **At least 2 consecutive months of income**
- ☐ **Return application and proof of income within 30 days of application date**

INCOME INFORMATION

Please list income for each member in your household (even if not related). If a member does not have income, please list "NONE". (YOU MUST PROVIDE 2 MONTHS OF CONSECUTIVE INCOME IN ORDER FOR US TO MAKE A DETERMINATION.)

YOU	SPOUSE	CHILDREN	OTHER PERSONS	TOTAL INCOME

NAME (LIST YOURSELF FIRST)	BIRTHDATE	INSURANCE	ACCT# (OFFICE USE ONLY)	OFFICE USE ONLY
				R__A__S__
				R__A__S__
				R__A__S__
				R__A__S__
				R__A__S__

TOTAL # OF HOUSEHOLD MEMBERS_____

APPLICATIONS WILL BE RENEWED EVERY **APRIL 30TH** ,EVEN IF THERE IS NO CHANGE IN INCOME. IF YOUR HOUSEHOLD INCOME OR SIZE CHANGES IN ANY WAY IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY THE HEALTH CENTER.

I DECLARE THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT I GIVE THE OZARKS COMMUNITY HEALTH CENTER PERMISSION TO INVESTIGATE ANY INFORMATION GIVEN IN THIS APPLICATION . I UNDERSTAND THAT THIS INFORMATION WILL BE KEPT CONFIDENTIAL. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE MINIMUM PAYMENT DUE AT EACH VISIT. I AM AWARE THAT THERE MAY BE ADDITIONAL CHARGES RELATED TO LABORATORY AND PATHOLOGY TESTS THAT MUST BE SENT OUT OF THE CLINIC. I AGREE THAT I WILL BE RESPONSIBLE FOR PAYING ALL COSTS ASSOCIATED WITH MY VISIT.

SIGNATURE _____ DATE _____

THIS SECTION TO BE COMPLETED BY OFFICE STAFF

ANNUAL HOUSEHOLD INCOME _____ #PEOPLE IN HOUSEHOLD _____ ____ R ____A ____S

PAYMENT LEVEL _____

MINIMUM CHARGE: Medical _____ Dental _____ DOES NOT QUALIFY____

OCHC EMPLOYEE SIGNATURE _____

EFFECTIVE DATE _____ EXPIRATION DATE _____

Dear Ozarks Community Health Center Patient:

Ozarks Community Health Center offers a discounted program to individuals/patients/families who qualify. Discounts for essential services are offered depending upon family size and income. If approved, you will eligible to receive a discount on your visit. Your copay must be paid at the time of each visit.

Please turn in the following when completing and returning your sliding fee scale application:

- Completed sliding fee scale application
- Name and Birthdates of everyone in the household
- Proof of income **(MUST BE 2 CONSECUTIVE MONTHS OF INCOME)**

If you receive any other sources of income, please provide information below.

	Yes	No	Amount
Social Security			
Supplemental Security Income (SSI)			
Alimony			
Child Support payments			
Money from other (friends, relatives, etc)			
VA Benefits			
Worker's Compensation			
Disability			
Rent received from land/buildings			
Any other income Explain:			
Has anyone recently applied for any of the above benefits? If yes, explain:			

It is required that we have 2 consecutive months of income in order to make a determination. Ozarks Community Health Center will only keep these applications on file for 30 days. After the 30 days has passed, it will be your responsibility to reapply and all pending charges will then become 100% your responsibility.