# Application for Sliding Fee Discount Program

**APPLICANT INFORMATION**

Applicant's Last Name _____ First Name _____ MI___

Social Security Number _____-_____-_____ Date of Birth _____

Driver's License or State ID # _____ State _____ Sex: Male Female

Address _____

City _____ County _____ State _____ Zip_____

Day Phone (_____) _____ Alternate Phone (_____) _____

Marital Status: Single Married Separated Divorced Widowed

*If married, provide spouse information:*

Spouse's Last Name _____ First Name_____ MI___

Social Security Number _____-_____-_____ Date of Birth _____

Driver's License or State ID # _____ State _____ Sex: Male Female

*Responsible party information (if different from applicant or spouse):*

Party's Last Name _____ First Name_____ MI_____

Social Security Number _____-_____-_____ Date of Birth _____

Driver's License or State ID # _____ State _____ Sex: Male Female

**Household Size: _____ Include all members in your household:**

| Full Name | *** | Gender | Birth Date | Social Security # | Relationship to Applicant | Marital Status |
|---|---|---|---|---|---|---|
| | | M F | | | | |
| | | M F | | | | |
| | | M F | | | | |
| | | M F | | | | |
| | | M F | | | | |
| | | M F | | | | |
| | | M F | | | | |

(*check here if the household member is applying for reduced fee services)

Initial here: _____

OCONEE VALLEY HEALTHCARE

Is anyone applying for the Sliding Scale Fee benefits are covered by Medicare, Medicaid or any other health insurance

Yes No

If yes, complete the following

| Name of the person(s) covered | Insurance Company | Policy Identification# |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**HOUSEHOLD INCOME**

List all persons in the household who are currently working and attach proof of income. If self-employed, please provide a copy of the most current Federal Income Tax return.

| Name/ Relationship | Employer/ Phone# | Wages Gross Amt/ Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Other Income (per month):**

Child Support $_____

Unemployment $_____

Begin Date: _____ End Date: _____

Worker's Compensation $_____

Begin Date: _____ End Date: _____

Disability benefits (including SSI) $_____

TANF, Public Assistance Funds $_____

Insurance Payments Received $_____

Retirement/ Pension Benefits $_____

Social Security Benefits $_____

Veterans Benefits $_____

Trust Fund Income $_____

**Additional Income**

List all income from alimony, boarders, cash contributions made by relatives or other persons, property rentals, mortgage income, interest, dividends, royalties, savings account, bonds, stocks, insurance, and other sources.

Source: _____Total per Month: $_____

Initial Here _____

OCONEE VALLEY HEALTHCARE

I understand that my participation in the reduced fee program will not be granted until I have completed the verification of eligibility process. Participation in the reduced fee program will be reviewed every 3-12 months depending upon the documentation submitted. Three (3) months for patients with no income and twelve (12) months for patients with income. It is my responsibility to schedule an appointment with Oconee Valley Healthcare at least three (3) weeks prior to the expiration date on the Oconee Valley Healthcare Benefits Card to renew my application. My next renewal date is: _____ Initial here: _____

I understand that my application and documentation must be current in order to receive discounts on services. I must notify Oconee Valley Healthcare within 10 days of a change in address, income, or family size. *Returned mail because of a change of address will stop by benefits until I have completed the application process again.* (If you are homeless, please notify our staff and do not sign this section.) Initial here: _____

I understand that discounts on services will only be applied to charges incurred during the approved enrollment dates. I am responsible for the full charge for the visit if I do not complete the application process, are deemed ineligible, or do not provide complete and accurate information. The Oconee Valley Healthcare Benefits Card must be presented at every visit in order to receive your predetermined discounts. Initial here: _____

I understand that my level of discounts is: _____ and not all services are eligible to receive discounts. *We expect patients to fully participate in the cost of their care*- we do not provide free care. **Payments are required for all patients at each visit.** Initial here: _____

I understand that Oconee Valley Healthcare will only grant credit on my account up to $200.00. I must also have a payment plan in place and be actively working to fulfill my obligation of my patient portion of my charges. Not all services are available for discounts or financing. I understand that I must pay my co-pay at every visit. Initial here: _____

I understand that my participation in the reduced fee program can be cancelled if: I move to another county, I have an increase in income level or a change in family size, I am non-complaint with my medical/dental plan of care, I am abusive or show inappropriate behavior with staff, I do not keep scheduled appointments (three (3) no-shows without notice of cancellation or failure to reschedule within 48 hours), I falsify my records/information, I am unwilling to pay patient responsibility portion of charges, and/or I do not maintain my records with Oconee Valley Healthcare. I understand that my failure to participate in the provider's recommended plan of care includes compliance with keeping my appointments, participation in the cost of care, pain management contracts, referrals to specialists/diagnostics, medication regime, and other relevant items as ordered by the attending provider. Initial here: _____

I affirm that the information I have provided to Oconee Valley Healthcare is true and accurate to the best of my knowledge. I understand that the information I have provided to determine my eligibility for this program that is provided by Federal Funds and is subject to review by Federal and State Audits. I understand that if I have provided false information, my participation in the program will be terminated. Initial here: _____

I authorize the release of information to Oconee Valley Healthcare of all data, records, information by insurance companies, providers of medical care, employers, financial institutions, federal, state, or local government agencies, and any other persons, agencies, or organizations necessary for Oconee Valley Healthcare's pursuit of third party reimbursement or verification of statements provided by me or any other person whose income and resources will be considered in this application. I understand that this signed application services as written authorization for any of the above person, agencies, or organizations to release the information required. Initial here: _____

Applicant Signature: _____ Date: _____

Oconee Valley Healthcare Witness Signature: _____ Date: _____

OCONEE VALLEY HEALTHCARE

# Unemployed/No Income Supplement

1. Are you looking for work? Describe your efforts.

2. Does someone provide you with housing, food, clothing, or cash? If so, please list their names and amount:

   Housing:

   Food:

   Clothing:

   Cash:

3. If you have no income and are not receiving help from friends or relatives, please explain:

   How do you pay rent?

   How do you buy food?

   What do you do for cash?

4. Is there a nonprofit or church organization assisting you with your living expenses? If yes, please list name, contact person, and type of assistance.

5. If you report no income, have you applied for public assistance? Yes No
   If yes, what type and what is the status?

Applicant Signature: _____ Date: _____

Oconee Valley Healthcare Witness Signature: _____ Date: _____

**Documentation needed for Income Verification:**

_____ Last 3 check stubs (for anyone *working* in the household)

_____ Department of Labor Wage and Earning print out (for any *non-working adult* in the household)

_____ Proof of Unemployment

_____ SSI/Disability Award Letter

_____ Proof of Child Support

_____ Proof of Food Stamps

_____ Picture ID

This documentation is due at your next appointment.

**Questions?**

Oconee Valley Healthcare
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