OCONEE VALLEY HEALTHCARE

Application for Sliding Fee Discount Program

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

Is anyone applying for the Sliding Scale Fee benefits are covered by Medicare, Medicaid or any other health insurance Yes No

Household Size: _____

Full Name	Birth Date	Social Security #	Relationship to Applicant
	/ /	- -	
	/ /	- -	
	/ /	- -	
	/ /	- -	
	/ /	- -	

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	Amount	Frequency (circle one)	Employer
You	$	Weekly Monthly Yearly	
Spouse/ Significant Other	$	Weekly Monthly Yearly	
Children (Combined)	$	Weekly Monthly Yearly	
Other (Combined)	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
Total	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security Benefits	$	$	$	$	$
Public Assistance	$	$	$	$	$
Retirement/ Pension	$	$	$	$	$

Your Slide Level: _____

Medical fees required for each slide level are listed below. You are expected to pay this fee at every appointment.

Level A: $30 • Level B: $50 • Level C: $70

Child Support	$	$	$	$	$
Disability Benefits (Including SSI)	$	$	$	$	$
Other	$	$	$	$	$
TOTAL	$	$	$	$	$

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 6-12 months depending upon the documentation submitted. Six (6) 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.

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.

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 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: _____

OVH Witness Signature: _____Date: _____

Your Slide Level: _____

Medical fees required for each slide level are listed below. You are expected to pay this fee at every appointment.

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