

## RURAL HEALTH CARE, INC. 2019 SLIDING FEE APPLICATION

Effective June 1, 2019 through May 31, 2020

Rural Health Care, Incorporated (RHCI) offers a sliding fee program, allowing patients to pay their fair share of the household's medical care. The sliding fee is determined on household size and income. As a Federally Qualified Health Center, RHCI is required to report basic income information to the Bureau of Primary Health Care (BPHC) and the Health Resources and Services Administration (HRSA). Only aggregate data is reported; personal information is kept strictly confidential and is not reported to either BPHC or HRSA.

The continuation of the program depends upon each patient making reasonable efforts to pay their portion of visit charges. Discounts will be applied retroactively for a 30 day period prior to the date the application is received by RHCI, provided that the application is completed within 30 days of receipt. If the application is not completed within 30 days, but is completed within 60 days of receipt by RHCI, the discount will be applied as of the date the application was received by RHCI but no additional retroactive period will be granted. If any portion of the application remains incomplete 60 days after application is received by RHCI, the application is void and a new application will need to be completed if you still desire consideration for sliding fee discount.

RHCI does not discriminate on the basis of gender, age, race, color, religion, national origin, handicap, parity, marital status, political beliefs or ability to pay. **ALL INFORMATION WILL BE KEPT CONFIDENTIAL**.

Patient Information (or Head of Household if patient is under 18)					
Last Name:	Last Name:		Other Names:		
City:	City:		Zip:		
Cell and/or Work Ph	Cell and/or Work Phone Numbers:				
Social Security #:	Marital St	tatus (circle one)			
	Single M	Married Divorced	Separated Widowed		
Do you have insurance? (circle one) Yes* No					
*If you have medical and/or supplemental insurance(s) you must supply RHCl clinics with a copy of your insurance card including your policy information so that we may file with your insurance prior to any Sliding Fee discount.					
	City:  Cell and/or Work Ph  Social Security #:  s* No  Insurance(s) you must supply	City:  Cell and/or Work Phone Numbers:  Social Security #:  Marital Single Numbers  Single Numbers:  Single Numbers:  Single Numbers:	Last Name:  City:  Cell and/or Work Phone Numbers:  Social Security #:  Marital Status (circle one)  Single Married Divorced  s* No  Insurance(s) you must supply RHCI clinics with a copy of your insurance		

Household Size – List all persons living in household including SELF				
Name	Relation to Applicant	Date of Birth	Social Security #	Health Insurance
	SELF			

Household Income - No applications will be processed without documentation of income					
Member Employed		Employer		Gross Income/Attach Documents	
Other Income – Check all that apply and provide documentation of income					
Social Security		Child Support			
Pension or Veteran's Benefit		Rental Income			
Unemployment Compensation		Interest or Dividends			
Alimony					
Other			Total	\$	

A \$25.00 nominal fee will be due at the time of each visit regardless of sliding fee eligibility.

I, the undersigned, agree that RHCI may contact each source of income for all persons working in the above-mentioned household. I also agree to notify the clinic within thirty (30) days if any change in financial status.

I understand that verification of income is *mandatory*. I understand and agree that services will only be discounted after the appropriate means of proof of income is provided. I understand it is necessary to reapply and update financial and/or household member and financial status at least annually to ensure RHCI maintains updated information.

I attest that the information set forth in this application is true and complete. I understand that any misrepresentation or omission may be grounds for rejection of consideration for, or termination of, any sliding fee discount. I acknowledge that it is my duty, in a timely fashion, to amend the responses and information I have provided if I come to know that the response or information was incorrect when given or, though accurate when given, the response or information is no longer accurate.

NOTE: To comply with federal regulations, in order to give you a discount on medical services, it is necessary for us to ask some personal questions. Information will be kept in strict confidence.

One of the following is required as proof of income: your yearly income tax return, a copy of your W-2 form, or two recent paystubs; in addition, please include copies of your social security award letter, or any other income you may receive. If after-tax checks are used as proof of income, 36.5% will be added to the total to account for the difference between gross and net income. Your annual income and your household size will be used to calculate your discount.

Applicant's Signature	Date