



Hyndman Area Health Center, Inc.

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2012 Reduced Rate Application

The information I have provided concerning the size of my family and my family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge.

I have given this information concerning my financial situation and my means and ability to pay for the purpose of procuring for my own and my families benefit the discount of my accounts with Hyndman Area Health Center, Inc. (HAHC). I understand that HAHC will rely on such information to determine applicable discount rate for my account.

I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the State of Pennsylvania.

I agree to report any change in either my income or my family size to HAHC before or at the time of my next contact or any contact by any family members with HAHC. I know that the information I have given will continue to be relied upon until it is changed.

I understand that my discount status will be reviewed on annual basis and adjusted according to my family income and size at the time of review. If HAHC has reason to suspect that the information I have given is untrue, inaccurate, or that I have not properly reported changes, HAHC may initiate a review of my status and I will authorize access to all my financial records. If I refuse an authorization, HAHC will no longer discount my account.

My signature below indicates that all information I have provided is true to the best of my knowledge. I also am stating that I have no health insurance coverage to pay for any or all of the services I have or will be receiving.

Signature

HAHC Representative

Date

Date

Name of Applicant _____
 Address _____
 Phone _____
 Employer _____
 Employer Address _____
 Employer Phone _____

Name of Spouse _____
 Address _____
 Phone _____
 Spouse's Employer _____
 Employer Address _____
 Employer Phone _____

List additional family members:

Insurance Information (covered family members)

Policy # _____ Policy Holder _____
 Relationship _____

Medicare Medicaid Other

Covered family members:

1. _____ 2. _____
 3. _____ 4. _____

I hereby authorize the investigation of all statements contained herein and authorize the release of all employment records, bank records and other financial information to an agent of Hyndman Area Health Center, Inc.

 Signature (Applicant/Head of Household)

Family Income Determination Worksheet

Family Size _____ Applicant Social Security Number _____

<u>Income Source</u>	<u>Income</u>	<u>Income Source</u>	<u>Income</u>
Wages (Head and household)	\$ _____	Pensions/Annuities	\$ _____
Personal business profits	\$ _____	Welfare Payments	\$ _____
Farm Income	\$ _____	Aid to Dependent Child	\$ _____
Seasonal Income	\$ _____	Alimony	\$ _____
Disability Income	\$ _____	Child Support	\$ _____
Unemployment Benefits	\$ _____	Veteran's Benefits	\$ _____
Social Security Benefits	\$ _____	Other (please specify; include interest & dividends)	
		_____	\$ _____
		_____	\$ _____

TOTAL HOUSEHOLD ANNUAL GROSS INCOME \$ _____

"A household includes all the persons who occupy a housing unit. A housing unit is a house, an apartment, a mobile home, a group of rooms, or a single room that is occupied (or if vacant, is intended for occupancy) as separate living quarters. Separate living quarters are those in which the occupants live and eat separately from any other persons in the building and which have direct access from the outside of the building or through a common hall. The occupants may be a single family, one person living alone, two or more families living together, or any other group of related or unrelated persons who share living arrangements. (People not living in households are classified as living in group quarters.)"

Name of Applicant _____

Federally Qualified Health Centers are required to obtain documentation to verify household annual gross income as well as proof of NO Income, such as:

1. W-2, 1099 or current year tax return *along* with most recent paystub **OR**
2. Statement from Pennsylvania Employment Commission approving or denying unemployment compensation which includes weekly benefit amount received **OR**
3. Termination/Layoff notice from previous employer **OR**
4. Social Security, Pension Fund, Disability statements reflecting monthly award amount **OR**
5. Personal statement of banking account(s) **OR**
6. Copy of lease agreement or statement from housing authority or individual landlord **OR**
7. Proof of Medicaid or welfare cancellation **OR**
8. Statement from agency reflecting alimony and/or child support award amount **OR**
9. Personal statement from person supplying patient with food and shelter if proven that patient has been determined to have NO source of income elsewhere defined **AND**
10. **Copies of a picture ID and/or Social Security card.**

In the event that a patient fails to provide federally required documentation at their initial visit, the patient will be approved for a Sliding Fee Level C – **for one (1) day only**. The patient will be responsible at the time of visit for payment of the minimal fee due. The discount will apply only to the patient and will not be applicable to additional family members. The patient must complete the sliding fee application with required income documentation for any future sliding fee discount. Once the application is returned completed and income has been documented a new sliding fee level will be established from that date forward. No retro adjustments will be made to the prior date of service even if the new sliding fee level is greater.

Determination of Reduced Fee Status

After careful examination of the applicant's family size and financial situation it is my determination this application for reduced fee status be:

Granted Denied

Reduced Fee Status Classification: A B C Private Pay

This status will remain in effect for one (1) year from this date or at any time income status changes, at which time the applicant's financial situation will be reviewed to reevaluate eligibility and classification.

Expiration Date: _____ **Authorized Signature:** _____