Sliding Fee Scale Discount Application

PrairieStar Health Center
non-profit • FQHC

APPLICANT INFORMATION

FULL NAME (First, MI, Last)	DATE OF BIRTH

CHECK HERE ONLY IF YOU **DO NOT** WANT TO APPLY FOR THE SLIDING FEE SCALE DISCOUNT

☐ I have been given the opportunity to apply for the PrairieStar Health Center, Inc. (PSHC) discount services sliding fee schedule. ***I DO NOT wish to apply for the PSHC discount services sliding fee program at this time.***

SIGNATURE OF PATIENT OR GUARANTOR	DATE

GENERAL INFORMATION

The questions on this form will only be used to gather information about you and your family, so we can better meet your medical, dental, behavioral health, and/or vision needs (if you are insured, you may qualify for discounted deductibles. If you are uninsured, you may qualify for discounted fees for services provided.) **This information will not be used to withhold or deny services.**

☐ Yes ☐ No Are you covered under Medicaid, Medicare, and/or any other insurance?

☐ Yes ☐ No Are you unemployed?

☐ Yes ☐ No Are you disabled?

HOUSEHOLD INFORMATION

Please include yourself, your spouse/partner, and all dependents receiving 50% or more of their support from the head of household.

Name	Date of Birth	Relationship to Applicant	Insurance	Insurance Type
		Self	☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:________

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INCOME VERIFICATION

Please enter your **gross income** *(the dollar amount received before taxes are taken out)* in the table below. Household income includes all income generated by everyone in the household. Proof of income is required before the discount goes into effect and must be received within 14 days of the date of service to be considered.

Type of Income (Before Taxes or Deductions)	NAME OF PERSON RECEIVING INCOME #1	NAME OF PERSON RECEIVING INCOME #2	NAME OF PERSON RECEIVING INCOME #3	HOW OFTEN DO YOU RECEIVE THIS INCOME?
Work Wages	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Cash Wages	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Disability Income	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Social Security	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Unemployment	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Worker's Comp	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Child Support	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Alimony	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Tips	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Self-Employment	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Pension	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
VA Benefits	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Other Income	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:

APPLICANT CERTIFICATION STATEMENT

I understand:

- this information is to be used to determine eligibility for the PSHC Sliding Fee Discount Program and proof of income must be received within 14 days of the date of service to be considered for that date of service.
- PSHC officials may verify information provided on this form.
- if I provide false information, I will be disqualified from the program and all charges will be due in full immediately.
- any insurance payments received by me or on my behalf must be applied to my account before I receive any discounts.

By signing this form, I certify under penalty of perjury under the laws of the State of Kansas that the above information is true and correct, and I assume the responsibility of contacting PSHC, should any changes to my financial or insurance status occur.

APPLICANT SIGNATURE	**DATE**

FOR OFFICE USE ONLY (to be calculated once proof of income is received)

TOTAL NUMBER IN HOUSEHOLD:		SLIDING FEE SCALE: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	
GROSS INCOME AMOUNT **#1**:	$	DATE OF COMPLETED APPLICATION:	
GROSS INCOME AMOUNT **#2**:	$	BACKDATE DISCOUNT TO:	
GROSS INCOME AMOUNT **#3**:	$	INITIALS OF PSHC REPRESENTATIVE:	
TOTAL GROSS INCOME AMOUNT:	$	ADMINISTRATIVE APPROVAL IF BACKDATE IS MORE THAN 14 DAYS:	
TOTAL ANNUAL HOUSEHOLD INCOME	$		