



Sliding Fee Scale Discount Enrollment Form

The Jordan Valley Community Health Center may be able to offer medical and dental services at a discounted rate based on the total number of members in the household and their combined income. To determine eligibility, appropriate documentation of income is required. If proof of income is not obtained, patient is responsible for payment in full at the time that service is rendered.

For Office Use Only
 Patient # _____ (in EHS)
 Total number of members _____
 In household _____
 Annual gross income form all _____
 Sources and of all members in the _____
 Household \$ _____
 Qualified for Sliding Fee Scale _____
 Discount Yes / No _____
 Slide Category _____

 Application processed by: _____

Applicant Information

_____ Last Name First Name M.I. Address (include apt. number)

_____ Phone Number (include area code) _____ City State ZIP

List the people in your household, include: *Yourself *Spouse *Children *Other individuals that live in the household

Last Name	First Name	M.I.	Date of Birth	Age	Social Security#	Relationship
						<i>Self</i>

Do you or any household member have or have applied for Medicaid, Medicare, Disability, Social Security, or any other Federally Funded Program? Yes / No
 If so, please list: _____

My signature below certifies under penalty of perjury that all declarations made in this eligibility statement for the receipt of federal funds are true, accurate, and complete. If there is a change in the number of household occupants or my household income, I will contact the intake department immediately. By signing below, I understand that I am responsible for paying at the time of service:

Medical: A minimum of \$20 co-pay per visit for adults/\$10 for children. Certain services requested by the patient that the provider deems not medically necessary will be full charge.

Dental: The cost of the exam will be discussed when the dental appointment is made. At the time of your appointment, a plan of treatment will be developed that will show how much you will need to pay for an extraction or any other service that is needed. You will then meet with a financial advisor from the dental clinic who will discuss the plan of treatment, the charges and method of payment.

_____ Applicants Signature _____ Date

My household income exceeds the federal poverty guideline. I am responsible for paying in full at the time of service rendered. I may re-apply for the slide program if there is a change in my financial situation.

_____ Applicants Signature _____ Date





Sliding Fee Requirements

No application will be approved without the following documentation.

- ❖ Documentation of all current **household** income for every member residing in the home.

Examples of acceptable documentation:

- ✓ The most recent 2 to 4 paycheck stubs
 - ✓ Individual or personal Tax statement, if it reflects current income, NO SCHEDULE C
 - ✓ Bank Statement reflecting electronic deposit for social security or child support, NO PAYROLL
 - ✓ Employer earning statement
 - ✓ Federal or state award letter
 - ✓ Benefit check
 - ✓ Statement of benefit
 - ✓ College award letter with total amount of grants or loans received
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- ❖ A letter from Family Support Division verifying an application has been filled for Medicaid within the past 3 months. You may go to your local office(Springfield location is 101 Park Central Square 417-895-6000) or you may see Susan Rapp at our Kearney location, call to verify if she will be available (831-0150)
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- ❖ A picture ID

No appointment necessary to apply for the discount program, but appointments are needed to see a medical provider.

We can not accept applications through the mail or fax. Applicants must come in person to apply.