 **Holistic, Inc. Sliding Fee Scale Application**

* **Are you 19 years old or older?**
* **Are you 64 years old or younger?**
* **Do you have a Medicaid or Medicare red white and blue card?**
* **Do you receive Social Security benefits?**

You may qualify for additional services if you are under 19 or over 65 or if you receive Social Security benefits. If you receive Medicaid, you do not qualify for the Sliding Fee Scale program. If you receive Medicare, it is still a possibility that you qualify for discounted services in addition to your Medicare card.

Please check any items below that you receive of have recently applied for:

* EBT Card (SNAP) from the DHHR
* Court ordered child support
* Retirement
* Unemployment
* Workers’ Compensation
* Welfare Assistance (financial or utilities)
* Housing Assistance
* Financial Assistance from a family member or friend
* Social Security or Social Security Disability

**\*If you receive ANY of the above items, you must provide verification of this income.**

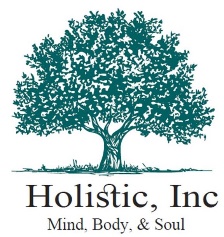
Example: We need current statements from DHHR, court orders etc.

**If you do not provide us updated information, your application will be incomplete and will not be processed!**

Please attach your proof of income to your application. If you need copies of your original documents, please see the front desk to copy them for you. We will need at least one of the following for proof of income for EVERYONE who receives any type of income in the home.

* 90 consecutive days of pay stubs (6 pay stubs if you are paid every two weeks, 12 pay stubs if you are paid every week)
* Most Current Social Security Awards letter
* A letter from your employer on company letter head stating your start date of employment, your hourly rate and the number of hours you average a week.
* A copy of your most recent 1040 tax form from where you filed your taxes. We cannot use w2’s! Please include your schedule C form if you are self-employed. If you or your family members do no file taxes, then we will need the 4506T form that is attached to this application completed and returned to us.

Jan/2019

 **Holistic, Inc. Sliding Fee Scale Application**

Date: \_\_\_\_\_\_\_\_\_\_\_

Total number of people in your living in your home: \_\_\_\_\_\_\_

First Name, Middle Initial, Last Name Date of Birth Patient SS Number Monthly Income

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Income is money earned before taxes (gross income), self-employment income, alimony, child support, retirement, Social Security, unemployment income, welfare assistance, SNAP benefits, financial assistance, or any other source of money your family uses to live on. Please include proof of income for the entire household. WE must receive 90 days PROOF OF INCOME in order to process application. Please provide us with you 1040 tax form for the previous year or 90 days of pay stubs.

**This information is true, correct and complete to the best of my knowledge and belief.**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name and Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Business Office Use – Do not write in this space

# in Household\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gross Monthly Income\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discount Nominal fee 75% 50% 25%

Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reviewed By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved for Sliding Fee Scale: YES NO

**Holistic, Inc. Sliding Fee Scale Program Agreement**

**I agree that the following has been explained to me and that I will follow all the guidelines of this program.**

1. Holistic, Inc. staff will review your application and let you know if you are eligible for the Sliding Fee Scale Program. Your enrollment is generally good for one year except for the patients with zero income. If you have no income at this time, your enrollment may expire in less than one year.
2. Only services that our medically necessary and ordered by staff of Holistic, Inc. are covered under this program.
3. Services that are paid for by other programs such as Medicaid, and any other program are not covered under this program.
4. Employment, camp, school and sports physicals are not covered under this program.
5. Some in-office procedures may not be covered by this program. If the service is not covered, the billing staff will assist you to make a payment arrangement.
6. Only laboratory services that are performed in our office are covered under this program. Some lab specimens are collected at our office but sent to an outside Laboratory for processing. These services may or may not qualify for a sliding fee. Please check with a Holistic, Inc staff member if you have questions.
7. Charges billed by a hospital or by a health care professional who is not part of our practice are not covered under this program.
8. Payment of Sliding Fee Scale fees are required at the time service is received. Please ask to talk with one of our Social Workers if you need further assistance.

* **I agree to bring in my Sliding Fee Scale Program card with me to every office visit.**
* **I agree to let Holistic, Inc. know if my income or household size changes before it is time to renew my application.**
* **I understand that I must bring in all documentation of proof of income for the entire household within 10 business days of services rendered or I will be billed full price for services already received.**
* **I understand that Holistic, In. staff has the right to ask for proof of income at any time during my participation in this program.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_