Sliding Fee Scale Application

Patient Information

				Received Date:_____	Received by: _____
What language do you speak? ☐English ☐ Spanish ☐Other_____ What language do you write? ☐English ☐ Spanish ☐Other_____ *Si Ud. Necesita esta formulario en español, por favor avisenos.*			Today's Date:	Legal Last Name	Legal First Name, MI
Birthdate	Gender ☐Male ☐ Female	Social Security #	Are you a US Citizen? ☐No ☐ Yes	Phone number	Other/Former/Maiden Name
Housing Information (check one) ☐Own ☐Rent ☐HUD/CHA ☐Homeless ☐Rent Free ☐Group Home		Are you a veteran? (check one) ☐No ☐Non-combat ☐Combat	Recently lost employment? (check one) ☐No ☐Yes	Place of birth (city, county, state)	Highest grade completed

Employment Information

Employment (check one) ☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Student ☐Disabled ☐Retired	Employer Name	Employer Phone Number	Title
	Employer Address	Date Hired	Recently lost employment? ☐No ☐Yes

For Dependents Only

Name of Parent/Guardian	Relationship to Patient	Family Size

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Insurance Information

Health insurance? ☐No ☐Yes	Medicare? ☐No ☐Yes If yes, policy #:	Equality Care/Medicaid? ☐No ☐Yes If yes, policy #:	Kid Care/CHIP? ☐No ☐Yes If yes, policy #:	Prescription Coverage? ☐No ☐Yes
Prescription coverage from Prescription Drug Assistance Program (PDAP)? ☐No ☐Yes		Medicare Part D ☐No ☐Yes	If unemployed, are you eligible for COBRA Benefits? ☐No ☐Yes Employer:	

Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Policy Holder Birth Date / /	Policy Holder Social Security # - -	Relationship to Patient

Secondary Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Policy Holder Birth Date / /	Policy Holder Social Security # - -	Relationship to Patient

Are you seeking Medical Care as a result of an Accident? ☐No ☐Yes If yes, answer following:

Date of Accident	Was it a motor vehicle accident? ☐No ☐Yes	Was the accident work-related? ☐No ☐Yes	Where did the accident occur?
Workers Compensation Number	If motor vehicle accident, name of auto insurance and policy number:		Do you have an attorney involved and/or settlement pending? ☐No ☐Yes

ASSIGNMENT AND RELEASE: I authorize Albany Community Health Clinic (ACHC) to disclose medical information as necessary to receive payment and assign all benefits, if any, directly to the ACHC that otherwise might be payable to me for services rendered. I understand that the ACHC may also release medical information about me to physicians or other health care providers who may be involved in my continued care. I understand that this authorization will remain in effect for twelve (12) months. If I choose to seek medical care with another provider, I understand that the treatment and information may still be shared with my insurance or other medical carrier. I understand that the ACHC will file an initial claim with Medicare, Medicaid, insurance, or any other third party, if I have provided and signed the necessary information and/or forms. I understand that I am financially responsible for all of my charges whether or not they are covered by my insurance carrier. I also agree to be responsible for payment of any services rendered if my insurance company takes longer than sixty (60) days from date of service. If this occurs, I will be responsible for seeking reimbursement from my insurance company. I authorize the use of this signature on all insurance submissions. I understand that if I fail to make a good faith effort to keep my account current at ACHC, ACHC reserves the right to refuse non-acute medical services and to engage a collection agency for any outstanding balances.

Signature of Responsible Party: _____ **Print Name:** _____

Relationship to Patient: _____ **Date:** _____

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Tell us about each member of your household.

Please list every household member claimed on your tax return. (Please use additional pages if needed.)

Household Member (relationship to applicant)		**Insurance Coverage?**	**Types of Income for Household Member** Gross total income <u>per month</u> (income before taxes and deductions are taken out)	
☐Self _____ Last Name _____ First Name MI	Gender: ☐Male ☐Female Birth Date: / / SSN: - - Can anyone claim you as a dependent on their tax return? ☐No ☐Yes	☐No ☐Yes Insurance Provider: ☐Medicare ☐Medicaid ☐_____	☐Wages $_____ ☐Self-Employment $_____ ☐Worker's Comp $_____ ☐Unemployment $_____ ☐Social Security/SSI $_____ ☐Military/Veteran's Benefits $_____ ☐Pension/Retirement $_____	☐Trust Fund Monies $_____ ☐Alimony $_____ ☐Child Support $_____ ☐Rental Income $_____ ☐Income from Investments $_____ ☐Other $_____ ☐No Income
☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: _____ _____ Last Name _____ First Name MI	Gender: ☐Male ☐Female Birth Date: / / SSN: - - Is this person included on your tax return? ☐No ☐Yes	☐No ☐Yes Insurance Provider: ☐Medicare ☐Medicaid ☐_____	☐Wages $_____ ☐Self-Employment $_____ ☐Worker's Comp $_____ ☐Unemployment $_____ ☐Social Security/SSI $_____ ☐Military/Veteran's Benefits $_____ ☐Pension/Retirement $_____	☐Trust Fund Monies $_____ ☐Alimony $_____ ☐Child Support $_____ ☐Rental Income $_____ ☐Income from Investments $_____ ☐Other $_____ ☐No Income
☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: _____ _____ Last Name _____ First Name MI	Gender: ☐Male ☐Female Birth Date: / / SSN: - - Is this person included on your tax return? ☐No ☐Yes	☐No ☐Yes Insurance Provider: ☐Medicare ☐Medicaid ☐_____	☐Wages $_____ ☐Self-Employment $_____ ☐Worker's Comp $_____ ☐Unemployment $_____ ☐Social Security/SSI $_____ ☐Military/Veteran's Benefits $_____ ☐Pension/Retirement $_____	☐Trust Fund Monies $_____ ☐Alimony $_____ ☐Child Support $_____ ☐Rental Income $_____ ☐Income from Investments $_____ ☐Other $_____ ☐No Income

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Tell us about resources belonging to each member of your household.

Please list every household member claimed on your tax return. (Please use additional pages if needed.)

Household Member	Resources Belonging to this Household Member	Amount or current value of resource	Resources belonging to this Household Member	Amount or current value of resource
☐Self _____ Last Name _____ First Name MI	☐Cash on Hand	$_____	☐Automobile Make_____ Model_____ Year____	$_____
	☐Checking Account	$_____	☐Automobile Make_____ Model_____ Year____	$_____
	☐Checking Account	$_____	☐Recreational Vehicle Make____ Model___ Year___	$_____
	☐Savings Account	$_____	☐Crops/Equipment/Livestock	$_____
	☐Savings Account	$_____	☐Property/Real Estate	$_____
	☐Certificate of Deposit	$_____	☐Property/Real Estate	$_____
	☐Stocks/Bonds/Annuities	$_____	☐Life Estate	$_____
	☐IRA/401/Keogh/Pension	$_____	☐Burial Space	$_____
	☐Burial Funds/Trusts	$_____	☐Safety Deposit Box	$_____
	☐Life Insurance	$_____	☐Contract for Deed	$_____
	☐Trust Funds	$_____	☐Promissory Note	$_____
	☐Settlements	$_____	☐Other Resource	$_____
_____ Last Name _____ First Name MI	☐Cash on Hand	$_____	☐Automobile Make_____ Model_____ Year____	$_____
	☐Checking Account	$_____	☐Automobile Make_____ Model_____ Year____	$_____
	☐Checking Account	$_____	☐Recreational Vehicle Make____ Model___ Year___	$_____
	☐Savings Account	$_____	☐Crops/Equipment/Livestock	$_____
	☐Savings Account	$_____	☐Property/Real Estate	$_____
	☐Certificate of Deposit	$_____	☐Property/Real Estate	$_____
	☐Stocks/Bonds/Annuities	$_____	☐Life Estate	$_____
	☐IRA/401/Keogh/Pension	$_____	☐Burial Space	$_____
	☐Burial Funds/Trusts	$_____	☐Safety Deposit Box	$_____
	☐Life Insurance	$_____	☐Contract for Deed	$_____
	☐Trust Funds	$_____	☐Promissory Note	$_____
	☐Settlements	$_____	☐Other Resource	$_____
_____ Last Name _____ First Name MI	☐Cash on Hand	$_____	☐Automobile Make_____ Model_____ Year____	$_____
	☐Checking Account	$_____	☐Automobile Make_____ Model_____ Year____	$_____
	☐Checking Account	$_____	☐Recreational Vehicle Make____ Model___ Year___	$_____
	☐Savings Account	$_____	☐Crops/Equipment/Livestock	$_____
	☐Savings Account	$_____	☐Property/Real Estate	$_____
	☐Certificate of Deposit	$_____	☐Property/Real Estate	$_____
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	☐Life Insurance	$_____	☐Contract for Deed	$_____
	☐Trust Funds	$_____	☐Promissory Note	$_____
	☐Settlements	$_____	☐Other Resource	$_____

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If **no income** is indicated:

If you have no income, please indicate which of the following you can provide as documentation:

☐A copy of denied unemployment letter,

☐A copy of the letter from the Department of Family Services that shows eligibility for the Wyoming SNAP program,

☐A letter from the Comea Shelter or Safehouse verifying a recent stay at the shelter.

Does anyone give you money on a monthly basis to pay your expenses? ☐No ☐Yes If yes, amount of monthly payment provided: $_____

Would you like more information about our payment plan arrangements? ☐No ☐Yes

Have you ever filed for bankruptcy or do you intend to? ☐No ☐Yes

If yes, what state? _____ Case #? _____ File date? _____ Discharge date? _____

Is the reason for the filing due to medical bills? ☐No ☐Yes

My signature indicates that all of the information I have provided is true and correct. I hereby grant permission to this agency to obtain and share the information I have provided for the purpose of determining eligibility for assistance. I understand that failure to disclose insurance coverage for services provided or any household income will exclude me from receiving discounts and the agencies in which I applied for discounts have the right to full legal recourse to collect full billed charges.

Signature of Responsible Party: _____ **Print Name:** _____

Relationship to Patient: _____ **Date:** _____

For Clinic Use Only

Print Name: _____ Date: _____

Signature: _____

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