OPEN DOOR COMMUNITY HEALTH CENTERS

ELIGIBILITY FOR SLIDING FEE DISCOUNT SCALE CO-PAYMENT

NAME	Office Use Only MRN #

This form is used to determine if you are eligible for a discount on the fees for your medical services. You must complete this form in order to receive a discount.

You must report all sources of income for the family members listed on this form. This includes:

- Wages or salary from employment
- Other earnings from employment, such as tips or commissions
- Earnings from self employment
- Child Support, Spousal Support, or Alimony
- Any other source of income
- Pension or Retirement income
- Social Security
- Disability payments
- Unemployment payments

We reserve the right to request evidence of your income in the form of pay stubs, tax returns, or other documents in order to qualify for discounts

List below all family members living in your household and supported by the family income. Once this form is completed, each family member with an Open Door Community Health Center account will be eligible for the discount.

FAMILY MEMBER FULL NAME	DATE OF BIRTH	TYPE OF INCOME	MONTHLY INCOME (before taxes or deductions)	OFFICE USE ODCHC Account #s	Entered by
Self					
TOTAL Family Size		TOTAL Family Monthly Income			

If you are reporting no income, you must describe your current means of support and/or living situation:

_____

_____

_____ DECLINED (by initialing I understand that I am not eligible for any discounts or programs)

I declare, under penalty of perjury, that the information I have given on this form is true, correct and complete. I understand that the giving of false information may make me ineligible for discounted services.

Applicant Signature: _____ Date _____

OFFICE USE ONLY/ SITE_____

Income Verified*: ☐ Yes (Expires 365days) ☐ No (≤200% FPL-Expires 30days) ☐ No (>200% FPL- Expires 365days)

Notified Patient about eligibility screening and application assistance through Open Door Member Services: ☐ Yes

This applicant is: ☐ Eligible for Discount of: ☐ A Scale ☐ B Scale ☐ C Scale ☐ D Scale ☐ $0 Co-pay**

☐ Not Eligible for Sliding Scale Discount

Termination date: _____

**$0 co-pay requires re-certification by Office Supervisor at each visit and can not be applied to family members.

Certified by Signature: _____ Date: _____

Routing Instructions: *Receptionist:* Document eligibility for each family member for each account type within registration. Enter date eligibility begins (the certification date on this sheet) for each eligible account. *Medical Records:* Scan form into record.

***ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for SFS≤200% and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS)**

OPEN DOOR COMMUNITY HEALTH CENTERS
ELIGIBILITY FOR SLIDING FEE SCALE CO-PAYMENT

NOMBRE	Office Use Only MRN #

Se usa este formulario para determinar si usted es elegible para un descuento en los cargos por servicios médicos. Debe llenar esta forma para poder recibir el descuento.

Debe apuntar los miembros de la familia y reportar todos los ingresos en la lista abajo. Esto incluye:

- Salario de empleo
- Otras ganacias del empleo, come propinas o comsiones
- Ganancias del empleo de si mismo
- Apoyo fiscal para el niño o la esposa, o alimenticia
- Cualquier otra entrada de dinero que recibe
- Pensión
- Seguro Social
- Discapacidad
- Desempleo

Reservamos el derecho de pedir evidencia de sus ingresos en la forma de talones de cheque, regreso de impuestos y otros documentos para poder calificar para los descuentos.

Indique abajo todos los miembros de su familia que viven en su hogar y que dependen del ingreso familiar para su sostenimiento. Una vez que esta forma está completa, cada miembro de su familia que tenga cuenta con Open Door Health Centers será elegible para el descuento.

MIEMBROS de la FAMILIA NOMBRE	FECHA NAC.	FUENTE DE INGRESO	INGRESO MENSUAL Antes de impuestos	OFFICE USE ODCHC Account #s	Entered by
Usted					
TOTAL Tamaño de la Familia		TOTAL Ingreso Familiar			

Si usted reporta que no tiene ingresos, debe describer como se mantiene y la situación en que vive:

_____

_____

_____ Rehuso (Comprendo que al poner mis inicialesno soy elegible para ningun descuento o programa.)

Declaro bajo pena de perjurio, que la información que he dado en este formulario es verdadera, corecta y completa. Entiendo que si doy información falsa, es posible que no sea elegible para el descuento.

Firma: _____ Fecha: _____

OFFICE USE ONLY/ SITE_____

Income Verified*: ☐ Yes (Expires 365days) ☐ No (≤200% FPL-Expires 30days) ☐ No (>200% FPL- Expires 365days)

Notified Patient about eligibility screening and application assistance through Open Door Member Services: ☐ Yes

This applicant is: ☐ Eligible for Discount of: ☐ A Scale ☐ B Scale ☐ C Scale ☐ D Scale ☐ $0 Co-pay**
☐ Not Eligible for Sliding Scale Discount

Termination date: _____

**$0 co-pay requires re-certification by Office Supervisor at each visit and can not be applied to family members.

Certified by:
Signature: _____ Date: _____

Routing Instructions: *Receptionist:* Document eligibility for each family member for each account type in PMS. Enter date eligibility begins (the certification date on this sheet) for each eligible account. *Medical Records:* Scan form into record.
***ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for SFS≤200% and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS).**