Insert Label Box here

APPLICATION FOR DISCOUNT SERVICES SLIDING FEE SCHEDULE

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical or behavioral health needs. **This information will not be used to withhold or deny services to you**.

Patient Information		
Name:	Telephone Number:	
Address:		
City:	State:	Zip:
Applicant (Guarantor) Information	□ *If same as above check this box and proceed to question #1.*	
Relationship to patient: □ Self □ Parent/Guardian		
Name:		Date of birth:
SSN:	Telephone Number:	
Address:		
City:	State:	Zip:

1. Are you covered under Medi-Cal, Medicare and/or any other insurance?	Yes	No
2. If you have private insurance, what is your out of pocket expense?	$_______	
3. Have you or your family ever applied for or been denied for Medi-Cal or Medicare?	Yes	No
4. Would you like to apply or re-apply for Medi-Cal today?	Yes	No
5. Are you unemployed?	Yes	No
6. Are you too sick to work or are you disabled?	Yes	No

Please include yourself, your spouse/partner and all dependents under 21 years of age living in the home below:

Name	Date of Birth	Relationship to Head of House	Insurance or Medi-Cal?
		Head of Household	**Yes or No**
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No

If additional dependent fields are needed, please document on page X

ALAMEDA HEALTH SYSTEM

Insert Label Box here

INCOME VERIFICATION

Please enter your **gross income** (the amount received before taxes are taken out). Household income includes ***everyone*** in the home. **Proof of income includes:** most recent tax return, check stubs, a letter from the employer stating wages earned, perjury statement or proof of unemployment.

If there is **no income to report**, please bypass the income table and proceed to the next step.

HOW ARE YOU PAID? AMOUNT? CIRCLE ONE?

Employment Income	**$**	**Weekly /Bi weekly /Other** **Part Time / Full Time**
Cash Income	**$**	**Weekly /Bi weekly /Other**
Disability	**$**	**Weekly /Bi weekly /Other**
Social Security	**$**	**Weekly /Bi weekly /Other**
Unemployment	**$**	**Weekly /Bi weekly /Other**
Worker's Comp	**$**	**Weekly /Bi weekly /Other**
Child Support	**$**	**Weekly /Bi weekly /Other**
Other Income	**$**	**Weekly /Bi weekly /Other**

Office Use Only

Income Verified FPL: _____

Identification Verified

Staff Signature:_________________________

Date: ____________

Patient Advised of Discount Rate: __________

Staff Initials

Enrollment Dates: __________ to ___________

Approved By:_________________________

Date: ____________

**PLEASE REFER TO THE CURRENT AHS SLIDING FEE DISCOUNT SLIDE SCHEDULE*

PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify the facility. I understand that I will be financially responsible for **all or a portion of my care** and that I will be asked to **submit payment at the time of service**. I authorize the release of any information necessary to establish my eligibility for discounted services and I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may enrolled.

Patient Signature_______________________________________ Date________________

Insert Label Box here

Declination Statement (for Patient's Who Do Not Want to Comply with Sliding Scale Requirements)

Because you do not wish to apply for our sliding scale discount, you are choosing to be a self-pay patient. This means that you will be responsible for any and all balances due after the self-pay discount. Office and lab charges are not applicable, and you will not be allowed to receive a discount for these charges.

Patient Signature____________________________________ Date_______________

COMPLETE BELOW FOR Self-Declaration of Income

Please complete the information below only ***if you have no other way to document your income***. All of the boxes below must be checked, and all the questions answered. Failure to complete this information will result in a denial of your application for a sliding scale discount.

- ☐ I get paid in cash.
- ☐ I do not get pay checks/pay stubs.
- ☐ I cannot get a letter from my employer. Explain why: ___________________________________
- ☐ I do not have access to my financial information, Explain why: __________________________

Patient Certification Statement

☐

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the AHS Sliding Fee Discount Schedule. I understand that AHS officials may verify information on this form.

Patient Signature____________________________________ Date______________________

Employee Certification Statement

I certify that I asked the applicant/recipient about all the sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Employee Signature_________________________________ Date _____________________