Northeast Valley Health Corporation

a california health+ center

Date of Service: _____________ Time: _______ Loc: __________________
Patient Name: ______________________________ Chart # ________________
Address: __________________________________ City: ___________________
Home: (___) ______________ Emg: (___) _______________
DOB: ___/___/___ Sex: _____ Age: ____ Act# ___________________
Ins. Plan: ____

(PLACE LABEL HERE)

SLIDING FEE DISCOUNT PROGRAM COVER SHEET

You applied on ______________for the following program at Northeast Valley Health Corporation:

- □ Community Health Center Sliding Fee Discount (medical, psychiatric, nutrition/education, L & D, etc.,(330 CHC)
- □ Ryan White Sliding Fee Discount
- □ Dental Sliding Fee Discount (330 CHC)
- □ Pharmacy Discount Program (330 CHC)
- □ Title X
- □ Mammogram (330 CHC) or see if patient qualifies for EWC/CDP

In order to complete the application, you must bring in ALL of the following documents within 10 days of the application date by________________________________.

Enter expiration date

Failure to follow through on the application process will result in all fees for services provided for last 10 days to be billed to you at our usual and customary rates without any discount and due immediately to NEVHC.

DOCUMENTS DUE:

□ **Proof of Income (any or all of the following will be accepted)**

a. Three most recent check stubs
b. Last Tax return with form 1040 or All 1099 or business schedule C or Statement of Business Profit or Loss
c. Notice from government agency stating amount of benefits (disability, GR, Unemployment)
d. Letter from employer stating hours, wages, frequency of work
e. Letter for retirement or pension income from previous employer/state/feds,etc.
f. Most recent year W2
g. Disbursement letter of retirement account funds
i. Affidavit/self-declaration (last resort see policy)

□ **Proof of Identification (any of the following will be accepted) ***

a. Government issued photo ID (DMV, CA ID, school ID)
b. Passport

□ **Proof of Address or County Residency ***

a. Letter post marked and addressed to you with address
b. CA ID or driver's license

BRING ALL DOCUMENTS TO:_____________________________________(NAME OF SCREENER)

Note to Patient: Documents will be copied and retained on file for auditing purposes only. All documents are strictly confidential and will not be shared with any outside agencies other than the program agency requiring the documents to qualify you for the program. (*not a requirement for 330 sliding fee discount eligibility but for purposes of ensuring NEVHC has correct patient information)

Northeast Valley Health Corporation
SLIDING FEE DISCOUNT PROGRAM ELIGIBILITY SCREENING FORM (NEV-121 rev 2-19)

Section A: Applicant information

Name of Applicant: ____
Address: ____
Phone: ________________________________ Alt Phone: _____________________________

Section B: Household information:

1. Applicant	**S.S.#**	**DOB**	**Relation to Applicant**	**Acct# / M R#**
2. Name	S.S.#	DOB	Relation to Applicant	Acct# / MR#
3. Name	S.S.#	DOB	Relation to Applicant	Acct# / MR#
4. Name	S.S.#	DOB	Relation to Applicant	Acct# / MR#
5. Name	S.S.#	DOB	Relation to Applicant	Acct# / MR#
6. Name	S.S.#	DOB	Relation to Applicant	Acct# / MR#

Total number in family supported by household income: ______________

Section C: Household Income: list all dependents in the household 14 year of age or older

Family member #	Wages/ Tips/self-employment	SSI	General Relief	CalWorks	Social Security/ Retirement/ Pension	Child Support	Alimony	Disability (SSDI)	Unemp/ Workmans Comp	All Other Income
	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$
TOTALS	$	$	$	$	$	$	$	$	$	$

Total Gross Household Monthly Income (all sources):$_______________

I certify that the above information is true and correct. I understand that I must report any changes in my income, family size or residence to this health center should anything change. Deliberate falsification will result in denial of future benefits.

Yo certifico que la información arriba mencionada es correcta y verdadera. Yo entiendo que debo reportar a la clínica cualquier cambio en mis ingresos, tamaño de la familia o residencia. Falsificación deliberada resultará en un rechazo de futuros beneficios.

______________________________	______________________________	______________________
Applicant-Print Name Escriba el Nombre del Aplicante	Applicant Signature Firma del Aplicante	Date Fecha

Name of the Screener: ____

Section D: Sliding Fee Discount Program Eligibility

Have patient initial the level of subsidy they have been assigned based on income determination.

Federal Poverty Level Category:	**Patient Initials:**
□ A = 100% or less	A: _________
□ B = 100% + $1 to 125%	B: _________
□ C = 125% + $1 to 150%	C: _________
□ D = 150% + $1 to 175%	D: _________
□ E = 175% + $1 to 200%	E: _________
□ F = 200% + $1 to 225%	F: _________
□ G = 225% + $1 to 250%	G: _________
□ H = 250 % + $1 to 300%	H: _________
□ I = >300%	I: __________

Patient Qualifies for: Check Appropriate Box
□ 330 CHC SFD-(service on form 5A) **(A up to E)**
□Title X **(A-G)**
□ RW **(A-I /VN Adult only**)

Is Patient Homeless? ___YES ____NO (if YES, refer to Homeless program)

□Over Income (Have Patient sign acknowledgement below)

*** Eligibility period: FROM _________ TO __________ (Enter this certification into EPM)**
*** Periodo de certificación DATE/FECHA DATE/FECHA**

*This date is once applicant has finalized eligibility screening process (all documents submitted).
*Esta fecha es una vez que el solicitante ha finalizado el proceso de selección de elegibilidad (todos los documentos presentados).

Signature of Applicant: ____
Firma del Aplicante

TEMPORARY ELIGIBILITY:

You have been granted TEMPORARY ELIGIBILITY for a NEVHC sliding fee discount program.
Proof of income is required within 10 days of service. If I fail to bring in the required documents **within 10 days**, this will cause me to forfeit my eligibility for the sliding fee program and full payment for services rendered to date will be due in full. (See cover sheet for a list of documents due).

Se le ha otorgado ELEGIBILIDAD TEMPORAL para un programa de descuento de tarifa de NEVHC.
Se requiere comprobante de ingresos dentro de los 10 días del servicio. Si no llevo los documentos requeridos dentro de los 10 días, esto me hará perder mi elegibilidad para el programa de descuento de tarifa y el pago total de los servicios prestados hasta la fecha será total. (Consulte la hoja de portada para obtener una lista de documentos pendientes).

Temp Eligibility period (10 days): FROM _________ TO ________ (Enter this certification into EPM)
Periodo temporal de eligibilidad (10 dias) DATE/FECHA DATE/FECHA

Signature of Applicant: ____
Firma del Aplicante

OVER INCOME—NOT ELIGIBLE FOR SLIDING FEE DISCOUNT
I have been informed that I do not meet the eligibility criteria for a sliding fee discount. I understand that if my income or family size changes, I may reapply for this program.
Me informaron que no cumplo con los criterios de elegibilidad para un descuento de tarifa. Entiendo que si mi ingreso o el tamaño de mi familia cambian, puedo volver a solicitar este programa.

Signature of Applicant: ______________________________ Date of Denial: ______________________
Firma del Aplicante Fecha de Denegación