APPLICATION FOR DISCOUNT SERVICES SLIDING FEE SCHEDULE

PATIENT NAME: _____ HOME/CELL NUMBER: _____

STOP HERE IF YOU DO NOT WISH TO APPLY FOR MCR HEALTH DISCOUNT SERVICES (SFS) AND SIGN AT THE BOTTOM OF THE PAGE

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, behavioral health, and/or dental needs. **This information will not be used to withhold or deny services to you**.

1. Are you covered under Medicaid, Medicare and/or any other insurance? Yes No
2. Have you or your dependents ever applied for or been denied for Medicaid or Medicare? Yes No
3. Would you like to apply or re-apply for Medicaid today? Yes No
4. Are you unemployed? Yes No
5. Are you too sick to work or are you disabled? Yes No

Please include yourself, your spouse, partner (including same sex marriages which are recognized in any State and parent of applicant child, does not include domestic partners or civil unions), related by birth and are included considered dependent by Federal Tax Laws, foster children. Unrelated individuals who are not dependents living at the same address are considered separate households:

Name	Date of Birth	Relationship to Head of House	Insurance or Medicaid?
		Head of Household	Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No

INCOME VERIFICATION

Please enter the **gross monthly income (**the $ amount received before taxes are taken out). Household income includes ***everyone*** in the home listed above. Proof of income includes most recent tax return, check stubs, bank verification, and a letter from the employer stating wages earned or proof of unemployment, most recent 1 month bank statement.

INCOME TYPE	AMOUNT	HOW OFTEN	EMPLOYER, IF EMPLOYED	PERSON RECEIVING INCOME
Work Wages	$			
Social Security	$			
Disability Benefits	$			
Alimony	$			
Unemployment	$			
Interest	$			
Child Support	$			
Workers Compensation	$			
Other	$			
Total	$			

☐ **I have been given the opportunity to apply for the MCR Health discount services sliding fee schedule, and I DO NOT WISH TO APPLY FOR THE MCR HEALTH DISCOUNT SERVICES SLIDING FEE PROGRAM AT THIS TIME and I am choosing to be a self-pay patient. This means that I will pay a base charge up front at the time of service and I will be responsible for any and all balances due after the provider's charges for my visit are entered. I will also be responsible for any lab and/or x-ray charges.**

Patient Signature _____ Date _____

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PATIENT ACKNOWLEDGEMENT STATEMENT

Patient Certification Statement

I certify that the information provided on the Application for Discount Services is accurate and complete to the best of my knowledge. 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 family's 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 be enrolled.

Patient Signature_____ **Date**_____

ATTENTION: Florida Statute § 817.50 provides that willfully providing false information to a health care provider for the purpose of obtaining goods or services is punishable as a felony in the third degree.

Office Use Only:

Verified information contained in the application including supporting documentation is accurate and complete in the EMR.

Proof of income is attached: Yes No
Proof of ID is provided: Yes No
Proof of address is provided: Yes No
Confirm Zirmed and Availity were obtained: Yes No

Patient advised of discount rate and date to renew: Yes No
Verified income is calculated correctly in EMR: Yes No
Application for Discount Services was completed: Yes No

Employee Signature_____ Date _____

Employee Print Name: _____

PENDING _____

ELIGIBILITY MET DATE: _____

ELIGIBILITY NOT MET DATE: _____

DECLINED _____

PENDING _____

ELIGIBILITY MET DATE: _____

ELIGIBILITY NOT MET DATE: _____

DECLINED _____

NOTARIZED SELF DECLARATION

I _____, attest that I am unable to pay for my medical, dental, pharmacy and/or behavioral health services which are provided by MCR Health because I am currently unemployed and have had no income since _____. I was last employed on _____.

The reason I am not employed is: _____

_____

_____

I am currently receiving support from: _____
Name of person or agency

_____
Address

_____
City, State

_____
Telephone

Once I am employed, I must inform MCR Health of my change in income and if I am now receiving health insurance coverage. At that time, I will be re-evaluated for eligibility for discounted services.

I further understand that this statement is only effective for 90 days and that the expiration date is_____.

_____ _____
Patient/Guarantor Signature Date

COMPLETED BY NOTARY

Sworn before me this _____ day of _____, 20____, the above statement is

true. Personally known or identification provided: _____

_____
Notary Public

SUPPORT FORM

To Whom It May Concern:

I, the undersigned, verify that I, [__ give __loan] money to _____
(check one)

To help with living expenses each month. In the month of _____, 20____ I [__give ___loan]
(check one)

the amount of $_____. This support is not employment income.

CHECK ALL THAT APPLY:

The money was provided directly to the named applicant to help pay household expenses.

__I pay this money directly to the company (ies) to cover expenses for the named applicant's household. List company (ies) _____

__ I provide food and shelter only.

__I will continue to do this each month.

__I will not continue to do this. I am only helping temporarily or until _____.

_____ _____
Signature of Person Helping Household Date

_____
Print Name of Person Helping Household

Address: _____
Number & Street/PO Box City State Zip

Contact Number: (_____) _____-_____

COMPLETED BY NOTARY

Sworn before me this _____ day of _____, 20____, the above statement is true. Personally known or identification provided: _____

_____
Notary Public

VERIFICATION OF EARNINGS FORM

Dear Employer:

An employee of your company has applied for the Discount Services Program at MCR Health. Please complete this form and return it to the employee.
Thank you for your cooperation.

Name of Employee: _____

Address: _____
Number & Street/PO Box City State Zip Code

It is hereby certified that the individual named above is employed by the undersigned, and that the following wages and hours represent a normal rate of this individual for the most recent 4 week period.

Number of hours worked per week (average) _____

Average Gross Weekly Income $_____

Name of Employer: _____

Address: _____
Number & Street/PO Box City State Zip Code

Telephone Number: (_____) _____-_____

Does employee have health insurance coverage? ☐ Yes ☐ No

PERMISSION TO RELEASE WAGE/INSURANCE INFORMATION

_____
Employee Signature Date

_____
Employer Representative Signature Date

_____
Employer Representative Printed Name

Please fax completed form to: _____

If unable to fax, please have employee return form.

MANATEE COUNTY HEALTH CARE PROGRAM

1. Patient name : _____ Other name used: _____

2. Home Address: _____

3. Mailing Address: _____

4. Telephone: _____ Other Telephone:_____

5. Other Health Care Coverage? YES____ NO ____
   (Proof of award, claim letter, insurance policies, court documents, legal papers, Medicaid, Health insurance Medicare, V.A., Tricare)

6. Is this related to worker 's compensation? YES____ NO____

7. Are you pregnant? YES___ NO___ Are you over the age of 65? YES____ NO ____

8. Are you receiving Social Security Disability? YES____ NO ___

   ***if you answered yes to questions 5 ,6, 7 or 8 you must first apply for Medicaid and receive a denial letter before applying for Manatee County Health Care Program.

9. Male ____ Female _____

- I agree to give to the eligibility staff and the county any information necessary to prove statements about eligibility.
- I agree to report any of the following changes within 14 days: income, number of people who live with me, address, application for or receipt of SSI, TANF or Medicaid.
- I understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability or political belief.
- I may request a review of the decision made on my application/re-certification for assistance; and that I may request, verbally or in writing, a fair hearing about actions affecting the receipt or termination of health care assistance.
- I understand that by signing this application, I am giving MCR Health and Manatee County the right to recover the cost of health care services by the county from third party.
- I agree to give the county any information needed to identify and locate all other sources of payment for health care services.
- I have been informed and I understand that my failure to meet the obligations set forth may be considered intentional withholding of information and can result in the recovery of any loss by repayment or by filing civil or criminal charges against me.

Do you wish to apply for the Manatee County Health Care Program? YES____ NO____

Applicant's Signature_____ **Date**_____

Employee Signature _____ **Date** _____