Bluegrass Community Health Center

SLIDING FEE DISCOUNT APPLICATION

Sliding Fee Discount Information

It is the policy of Bluegrass Community Health Center (BCHC) to provide essential services regardless of the patient's ability to pay. BCHC offers discounts based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount. The discount will apply to all services received at this clinic, including 340B pharmaceuticals, x-ray interpretation by a consulting radiologist, and other such services.

Patient First Name	Last Name	Middle	Patient Date of Birth:

Household Size (list all family members residing in your household including applicant)

Name:	Date of Birth:

Income Verification (list all sources of income received by family members residing in your household on a separate line)

Name:	Relation to Patient:	Income Type:	Gross Pay:	Frequency: Weekly (52); Every Other Week (26); Twice a Month (24); Monthly (12)
		Household Total:		

Note: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

BCHC offers several programs to assist patients with paying for health care services and medications. Each of these programs have specific criteria for enrollment and verification; however, all programs require this information be updated on an annual basis. We cannot provide a discount without a completed application and income verification. Today's visit will be discounted based on the information provided above. If you do not have documentation for today's visit, you will be considered self-pay until verification of your income is received. **Verification must be received before the next visit or within 30 days (whichever comes first).** If you fail to provide the needed verification, you will be responsible for the full cost of all services provided. BCHC reserves the right to withdraw discounts for failure to provide correct information. It is your responsibility to inform us immediately if your financial situation changes in income and/or insurance status.

I attest that I have read the above statements and am completing this financial statement accurately to the best of my knowledge. I certify that the family size and income information shown above is correct.

Signature:_____ Date:_____

Office Use Only

Account Number:

Sliding Fee Level					Effective Date	Expiration Date	Employee Name
A	B	C	D	E			

Verification Checklist	Yes	No	Employee Name
Identification/Address: Government issued ID, other_____	☐	☐	
Income: Prior year tax return, most recent pay stubs, or other _____	☐	☐	