Due Date _____

Financial Discount Application Information

Please retain this page for your reference. Complete the next page and return it to SRCHC by the due date if you wish to apply.

SRCHC is a private, non-profit health center which provides quality and affordable medical services. All patients may apply for a sliding scale discount; eligibility is based on household size and income. *No one* is turned away due to lack of funds. All patients will receive a monthly statement if there is a balance owed on their account. All balances are due within 30 days of the statement date. If you are unable to pay your balance in full, please call SRCHC's billing office to make payment arrangements.

Any information you provide on this application will be used to help determine if you also qualify for a discount on services provided by Mercy Outpatient Lab & Imaging ordered by SRCHC. Information on this form may be requested by Mercy and will be provided to them for auditing purposes.

- Please complete this entire form and provide all requested documents in order to be considered for a sliding scale discount. Discounts will only be given to patients who qualify and provide verification.
- You have **14 days from the date of service** to complete and return this form in order to be considered for a discount on your visit. Otherwise, your discount will begin on the date it is returned.
- SRCHC will not back date discounts.
- Once your application has been processed, you will receive a letter in the mail notifying you of the discount that you are eligible for.
- All discounts will be valid for 6 months at which time you will be asked to provide current verification. **If your financial or living circumstances change before this date, you are required to notify SRCHC.** This information may adjust your discount.

Required Documents

In order to be determined for a sliding scale discount, please ensure copies of the following documents *for ALL household members are included with your application.* **If one or more of these documents do not pertain to your household, please disregard those documents.**

- ☐ Most recent 3 months of pay stubs
- ☐ Unemployment verification
- ☐ Most recent federal tax return (if self-employed)
- ☐ Social Security and/or Disability award letters
- ☐ Pension award letter
- ☐ Child Support award letter
- ☐ Worker's Compensation award letter
- ☐ Court orders from any lawsuit
- ☐ Proof of gambling winnings
- ☐ Proof of annuity payments
- ☐ Tuition assistance grants
- ☐ Receipts for goods sold or services provided
- ☐ If you have no income, a letter that explains your means of living or a completed Self Attestation of Income form (available upon request)
- ☐ Food Stamps verification
- ☐ Copies of bank statements (requested if other documentation is unavailable

Definitions

Household: persons who live in the same dwelling and are pooling resources.
Income: any moneys received, whether taxable or non-taxable, from any source. Any moneys for goods sold or services provided, grants for tuition assistance, retirement income, business income, social security and/or disability payments, unemployment insurance benefits, settlement awards from any lawsuit whether considered "economic damages" or not, life insurance payments, annuity payments, gambling winnings, and any other moneys received for the purposes of assisting with household expenses will be included. Loans or available credit will not be counted.

SouthRiver Community Health Center • PO Box 12 • 671 SW Main St. Winston, OR 97496 • 541.492.4550 • Fax: 541.492.4553 • www.south-river.org

If you are considering applying for a sliding scale discount, you may also qualify for the Oregon Health Plan (OHP). If you wish you apply for OHP and would like free assistance applying, please call 541-817-6109 to reach SRCHC's outreach eligibility worker. In order to be considered for a discount from Mercy Medical Center, you must have applied for OHP.

Have you applied for the Oregon Health Plan? Y N If yes, date applied: ____________ Were you approved? Y N

Do you have other insurance? Y N If yes, what insurance? ______________________ SRCHC staff initials ________

Please provide information for the person responsible for this account.

Name of Responsible Party:__________________________________Relation to Patient: ________________________

SSN: ___________________________________DOB: ______________ Phone: ________________________________

Billing Address: __________________________________ City: __________________ State: ________ Zip: ____________

Please provide information for all household members. (See definition of household on page 1).						
Household Member	**1**	**2**	**3**	**4**	**5**	**6**
Name						
Date of Birth						
Relationship to Patient	SELF					
Net Monthly Income from the following:*	***Please provide supporting documentation for each source of income listed.**					
Salary/Wages	$	$	$	$	$	$
Unemployment	$	$	$	$	$	$
Social Security	$	$	$	$	$	$
Disability	$	$	$	$	$	$
Pension	$	$	$	$	$	$
Retirement	$	$	$	$	$	$
Child Support	$	$	$	$	$	$
Worker's Comp	$	$	$	$	$	$
Sale of Goods	$	$	$	$	$	$
Other _______	$	$	$	$	$	$
TOTAL	**$**	**$**	**$**	**$**	**$**	**$**

TOTAL net monthly household income: ______________ **TOTAL** number of household members: __________

If your household income is zero, please initial here ________ and provide a brief explanation of your current financial and living situations: ____

____

I hereby authorize representatives of SRCHC to make whatever inquiries necessary to verify the information furnished on this form, or to release any information regarding my office visits to any insurance company or third party to seek settlement of this account. I hereby state that to the best of my knowledge the information given above is true and complete. I understand that if any information is found to be incorrect I may not be eligible for any future consideration of reduced rates and that any sliding fee taken in the past may be reversed and all accounts adjusted accordingly.

Patient/Responsible Party Signature: __________________________________ **Date:** _______________________

FOR OFFICE USE ONLY

Application Date: ____________________________________ Expiration Date: _________________________________

☐ **Based on the information provided, the above listed patient is eligible for a _____% discount with a $ _____ contribution.**

☐ **Based on the information provided, the patient is <u>not</u> eligible for a discount at this time.**

Information verified by: ☐ Pay Stubs ☐ Tax Return ☐Other ____

Staff member completing form: ____ Date: ________________________

Updated 06/04/18