Date Slide Received: ___/___/____

Received By: _____

Patient name: _____ Date of birth: _____ Account #: _____

CAREMED Discount Program
Eligibility Form

Name	Guarantor Relationship (Required)	Date of Birth (Required)	Income (Gross)	Frequency (Weekly, Bi- Weekly, Hourly, Monthly or Yearly)	For Internal Use Only	
					Date all Documentation Received	Document Received
	Guarantor					
Please provide official ID along with any insurance/Medicaid cards for those listed above					Income	Household
TOTAL NUMBER OF FAMILY MEMBERS YOU ARE RESPONSIBLE FOR:						

Guarantor is the head of household. The one responsible for paying the bills.

***Family is defined as anyone receiving 50% of their support from the head of household.*

*****Documentation must be provided by the patient or guarantor to determine eligibility for Sliding Fee Scale*****

1. I understand that the information I provide on this form is subject to verification by MedNorth Health Center.
2. I understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.
3. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to disqualification from the Sliding Scale Discount Program.
4. I understand that it is my responsibility to notify MedNorth Health Center of any changes in income or insurance.

_____ _____

PATIENT/GUARDIAN SIGNATURE **PRINT NAME** **DATE**

ACCEPTABLE INCOME DOCUMENTATION

*CURRENT FEDERAL TAX RETURN (Schedule C for self-employed)

*ONE MONTH OF PAY CHECK STUBS (last 30 days)

*COMPANY LETTER STATING ANNUAL EARNINGS (LETTER MUST CONTAIN A CONTACT PERSON AND PHONE NUMBER)

*OFFICIAL LETTERS/DOCUMENTS FROM: Social Security, VA, Courts, Employment Security Commission, Social Service Agency (i.e.-TANIF, WIC, Food stamps, etc.), SSI, Disability, Retirement, Student loans/grants

*LETTER OF SUPPORT (LINC, SOAR, Shelter, Transitional home, First Fruits, Pastors, etc.)

I am not interested in disclosing my financial information, therefore I acknowledge my family and I are not eligible for the Sliding Fee Discount Program. Signature: _____ Date: _____

For Internal Use Only

_____ _____

PROCESSED BY: **DATE** **DENIED/APPROVED** **SLIDE LEVEL**

_____ _____

SCANNED BY **DATE** **IF APPROVED, DATES VALID FOR:**