Camino Health Center
Affiliated with Mission Hospital

# CAMINO HEALTH CENTER
# SLIDING FEE DISCOUNT PROGRAM
# APPLICATION

It is Camino Health Center's policy to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. 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 the center but not those services which are purchased from outside, such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and similar services. In the hope that your economic health improves, discounts apply only to current, not future services. This form must be completed annually and/or if there are any changes. Please inquire at the front desk if you have questions.

**____ I do wish to apply**

**____ I do not wish to apply**

| | | |
|---|---|---|
| **Applicant Name:** | | **Chart #_____** |
| **Address:** | **City:** | **Zip Code:** |
| **Home Phone:** | **Cell Phone:** | **Work Phone:** |

**PLEASE LIST SELF, SPOUSE, AND DEPENDENTS UNDER THE AGE OF 18.**

| Name | | Date of Birth | Name | | Date of Birth | Total # in your household: |
|---|---|---|---|---|---|---|
| **Self** | | | **Dependent #3** | | | |
| **Spouse** | | | **Dependent #4** | | | |
| **Dependent #1** | | | **Dependent #5** | | | |
| **Dependent #2** | | | **Dependent #6** | | | |

| Source | Self | Frequency (weekly (52), bi-weekly (26), semi-monthly (24) or monthly (12)) | Spouse | Frequency (weekly (52), bi-weekly (26), semi-monthly (24) or monthly (12)) | *Total* |
|---|---|---|---|---|---|
| **Gross wages, salaries, tips, etc.** | | | | | |
| | | | | | |
| | | | | | |
| **Total income** | | | | | |

Note: Include income from yourself, spouse and dependents under the age of 18 in the household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, Veteran's payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.

| Verification checklist (Attach copies) | Yes | No |
|---|---|---|
| **Identification/Address: Government Issued ID** | | |
| **Income: Prior year tax return, three most recent pay stubs, or other** | | |
| **Insurance: Insurance card(s), applicable only if insured by 3rd party** | | |

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print): _____Signature: _____ Date: _____

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# CAMINO HEALTH CENTER
# SLIDING FEE DISCOUNT PROGRAM
# SELF-DECLARATION OF INCOME

**PATIENT'S NAME:** _____ **DATE OF BIRTH:** _____

Please check and complete the following information:

I, _____, declare that I have been working and receiving cash payments in the amount of $ _____ per (check one) _____ week (52); _____ bi-weekly (26); _____ semi-monthly (24); _____ monthly (12).

Name of Employer: _____

_____ I declare that I have no check stubs or other documentation to prove my earnings.

_____ I declare that I am unemployed and do not have any income at this time.

**I understand that any falsification or failure to report any income or changes in income may result in my being ineligible for the sliding fee scale adjustment to my charges for services.**

**SIGNATURE:** _____ **DAT**E: _____

**For staff use only**

I certify that this patient has no documentation for the proof of income:

Print Name: _____ Date: _____

**Signature of Patient Service Representative** _____

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**SLIDING FEE DISCOUNT PROGRAM**
**Advance Beneficiary Notice of Non-coverage (ABN)**

**NOTE:** If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| | | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

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