AMITY MEDICAL GROUP

Sliding Fee Scale Application

Amity Medical Group offers a sliding fee scale program to patients who need assistance in covering the cost of services. Proof of income and information about your household size is required for us to determine if you qualify for a discount in the cost of services. Please see below for acceptable forms of documentation to submit with your application.

Proof of income via one of the following:

- ❑ One month's worth of current paystubs from an employer
- ❑ Record of cash payments from an employer
- ❑ Retirement payments from Social Security or an employer
- ❑ Short-term or long-term disability payments
- ❑ Unemployment compensation
- ❑ Child support payments
- ❑ Alimony payments
- ❑ Cash assistance or food stamps from State or Federal agencies
- ❑ Workers' compensation payments
- ❑ Income from rental property
- ❑ Current bank statement
- ❑ W-2 form or Income tax return
- ❑ For clients who have no income, a signed statement of no income which should include a statement of any funds or support the client receives to cover basic living expenses
- ❑ If unable to provide one of the items listed here, please let our staff know so that we can work with you to determine appropriate proof of income for your situation
- ❑ If legally married, proof of income is also required for your spouse

Amity Medical Group reserves the right to request additional income information if needed.

Please continue to the next page to complete your application.

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Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Home Phone #:		Place of Employment:		
Date of Birth:	Social Security #:		Do you have insurance?	
Marital Status:	Single	In a relationship	Married	Divorced	Separated	Widowed

Household Size (Include members of your legal household such as spouse and dependents)	
Name	**Relationship**

Household Income

Name	**Amount (Gross)**	**Pay Frequency (Circle One)**	**Employer**
You	$	Weekly Biweekly Monthly Yearly	
Spouse	$	Weekly Biweekly Monthly Yearly	
Children	$	Weekly Biweekly Monthly Yearly	
Other	$	Weekly Biweekly Monthly Yearly	
	$	Weekly Biweekly Monthly Yearly	
TOTAL	$	Weekly Biweekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Amount (Gross)**
Social Security					$
Public Assistance					$
Retirement Pension					$
Food Stamps					$
Child Support, Alimony					$
Unemployment					$
Interest Income					$
Other					$
				TOTAL	**$**

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I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program. I have read the above and understand that if my application is approved, I am responsible for a portion of my fees based on the schedule. My portion is due at the time of my visit. I understand that I am to notify the Patient Accounts Department of Amity Medical Group if there are any changes to my income.

Date: _____

Name (Print): _____

Signature: _____

Office Use Only

Patient's Annual Income (Calculated based on proof of income): $ _____

Patient's Family Size: _____

Patient's FPL: _____

Physician Copay: $ _____

Annual Cap on Charges
(For Ryan White patient population only)

Formula for Annual Cap on Charges: Annual Income X Annual Cap Percentage = Annual cap
Example: $21,000 (single household) X .05 (101-200% of FPG) = $1050 (annual cap)

Maximum Annual Cap: $ _____ **(annual income) X** _____ **(percentage based on current FPG) = $** _____

Intake Staff Member: _____