LITTLE RIVERS HEALTH CARE

A Federally Qualified Health Center

APPLICATION for FINANCIAL ASSISTANCE

Sliding Fee Scale

Thank you for choosing Little Rivers Health Care (LRHC) as your health care provider. If payment of your medical bills creates a financial hardship for you, our staff will work with you to apply for financial assistance. **Please note that before any financial assistance can be provided by LRHC, our staff will work with you to identify other sources of payment. If we identify a potential payment source, you will be expected to cooperate with us to determine if you qualify for that program.**

Please note:

- Co-Pays are set by your Insurance Company and are always due at the time of service.
- Co-pays, Co-insurances and patient deductibles are all eligible for the Sliding Fee Scale.
- Patients on the Sliding Fee Scale must re-apply annually before March to determine/maintain eligibility based on new Federal Poverty Guidelines.
- The discount will apply to services received at our offices with the ***exception of***:
    - Birth control devices – Mirena, Paraguard, Implanon
- The discount **is not** applied to services purchased from outside agencies i.e. lab testing, x-rays and entities other than LRHC unless they are one of our discount partners.
- Our discount partners, Cottage Hospital, Woodsville Eye Care and Quest Diagnostics, have agreed to accept our sliding fee scale discount. However, the discount may be higher than what we offer if you apply for their financial assistance program directly, which may result in a larger discount.
- If there is special financial circumstances i.e. catastrophic medical/healthcare condition, please ask to speak with the Care Coordinator.
- Participating pharmacies include Kinney Drugs in Bradford, VT. and Walmart Pharmacy in Woodsville, NH.

Submit your application including all required documents to the Care Coordinator at the site you receive services. They will review your application to make sure it is complete and all documentation is attached. If you are missing any documentation, please let them know so they can assist you in identifying and collecting information that may be missing. **Incomplete applications lacking any required information/ documentation cannot be forwarded for processing and can be destroyed without notice after thirty (30) days.**

Completed applications are forwarded to the Revenue Cycle Manager to determine your eligibility for a discount. If determined you are eligible, your discount will be applied to your outstanding balances for that discount year. You will also receive a drug prescription card in the mail from ProAct indicating your discount percentage**.** ***Please watch for this card in the mail*****.** This card can be used at any of our 340B pharmacies and as proof of your discount for our discount partners. If you are not eligible, you will be notified by your Care Coordinator.

Did you remember to include the following for yourself and all household members also applying for the discount:

- Copies of most recent tax return including all schedules & attachments.
- Copies of three most recent pay stubs or a signed wages statement from their employer.
- Copies of last two bank statements for all savings/checking accounts.
- Copies of current year's social security annual benefits letter.
- Copies of unemployment, pension or disability compensation benefit statements.

LITTLE RIVERS HEALTH CARE, INC.

SLIDING FEE SCALE APPLICATION

All sections and questions must be answered. If a section or question does not apply, write in "N/A".

APPLICANT'S INFORMATION

Your Name: _____ Your Date of Birth: _____

Your Social Security #:_____ Your Telephone #:_____

Your Mailing Address: _____

_____

Your Employment Status: (Please Circle) Employed, Unemployed, Self-Employed, Disabled, Retired, Student, Minor

Indicate type of health insurance you have: Commercial Medicare Medicaid No Insurance

YOUR HUSBAND/WIFE/PARTNER INFORMATION

Husband/Wife/Partner Name: _____ His/Her Date of Birth:_____

His/Her Social Security #:_____ His/Her Phone #: _____

His/Her Employment Status: (Please Circle) Employed, Unemployed, Self-Employed, Disabled, Retired, Student, Minor

Indicate type of health insurance they have: Commercial Medicare Medicaid No Insurance

HOUSEHOLD MEMBER INFORMATION

Please list and complete all columns for all household members (including wages earned in another country).

Name of Household Member	Relationship to Patient	Date of Birth	Are they Employed Yes or No	Do They Have Any Income Yes or No ***
1.				
2.				
3.				
4.				
5.				

If someone else is providing you with shelter, heat, and electricity, the value of these accommodations is considered "income" and will be calculated per household member at **$600.00 per month** ($7,200 annually).

******Please read the following statement carefully and initial here:*** _____

"I declare that the household members I listed above as not having any income do not receive income from any source"

To Be Completed By the Care Coordinator:

Applicant LRHC Location: _____Applicant LRHC Account #: _____

Other Household Members Locations: _____Other Household Member Account #:_____

REQUIRED DOCUMENTS TO VERIFY INCOME

Please provide a copy of your two most recent bank statements and a complete current year federal tax return including all schedules. (If you do not file please circle "NO" below).

Do you file an income tax return? YES NO If "YES" but your income has changed since filing your most recent tax return, please provide us with some documentation supporting your claim.

Do you have any bank accounts? YES NO If "NO" how do you cash checks and pay bills.

Each person you listed as a household member, who would like to be included in this application for a discount must provide the following documentation:

TYPE OF INCOME	WHAT IS REQUIRED FOR VERFICATION	TYPE OF INCOME	WHAT IS REQUIRED FOR VERFICATION
*Employer Paid Wages	Three (3) most recent pay stubs	Pension	Statement or Proof of Bank Deposit
Self-Employed	Two most recent bank statements & Complete Federal tax return with all schedules	Annuity/IRA	Statement or Proof of Bank Deposit
Social Security	Current Year Benefit Letter	Unemployment	Benefit Letter
Disability	Current Year Benefit Letter	Worker's Comp	Benefit Letter
401k Withdrawal/Distribution	Form 1099-R, Proof of Bank Deposit or Proof of Rollover	Child Support	Court Order or Signed Letter from Payor
Dividend Income	Form 1099-DIV or Proof of Bank Deposit	Alimony	Court Order or Signed Letter from Payor

*Note: If pay stubs are not provided by the employer, a signed earnings statement from the employer will be accepted.

It must show dates of pay period, gross pay, deductions, and net pay.

ADDITIONAL INFORMATION

1) Do you pay child support or alimony? Yes No If yes, how much: $_____ per _____. (Please attach a copy of the court order or signed letter from recipient).

2) I pay for my housing as follows: ☐ I own my home ☐ I rent my home ☐ I do not pay for housing ☐ My employer provides free housing

3) If you are not paying for housing, who provides you with housing, food & utilities _____

APPLICANT AGREEMENT

I have reviewed this application with my care coordinator. All sections are complete and all required documents are attached. I understand that discounts will not be approved if any requested information is missing.

I certify that the household member information, including all incomes received, is true to the best of my knowledge and that all supporting documentation is also complete and true to the best of my knowledge. I understand that a false answer to any part of the application may jeopardize my status with LRHC.

If I am approved for the LRHC Sliding Fee Scale, I agree to tell LRHC of any changes in circumstances, including changes to household size, household income, health insurance coverage, deductions, etc. as soon as they happen.

Applicant Signature_____ Date_____