

Discount Program Application

New Patient Returning Patient

This application only lasts for 12 months after date approved. The family/household must re-apply at least once a year. The family/household must provide updated information if: (1) the family/household financial situation change significantly (e.g., lose employment, obtain employment, change in household, etc.) and/or receives insurance coverage after approval date but before 12 months has passed; or (2) more than one year has passed since the last visit to the Center.

Person Responsible for Bills/ Head of Household

Last Name:		First Name:		Middle Name:	
Street Address:			City:	Zip Code:	Phone Number:

Income and Insurance Status

What is your annual income? \$ _____ <input type="checkbox"/> No Income <input type="checkbox"/> Patient w/Coverage Decline To Provide Info				What is your family size?	
Do you have Medical Insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have Dental Insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you have Medical Insurance, what type?	<input type="checkbox"/> Private	<input type="checkbox"/> Medicaid/ Husky	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other	

Do you want to participate in FHCHC discount programs?	<input type="checkbox"/> Yes, I will like to participate in the discount program and will provide proof of income	<input type="checkbox"/> No, I will not participate in the discount program
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Household Member Name	Relationship to Applicant	Date of Birth	FHCHC Patient?	Income	Pay Frequency (Weekly, Bi-Weekly or Monthly)	Income Source*
	Self			\$		
				\$		
				\$		
				\$		
				\$		
				\$		
				\$		

* Income sources include: Employer, Self-Employed, Unemployment Benefits, Social Security, Social Security Disability, Pension, Rental Income, Alimony/Child Support, No Income

Proof of Income Provided

2 most recent paystubs	Recent W-2's	Letter from Employer
Unemployment benefits letter	Completed tax returns	Self-Declaration Form
Other		

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I acknowledge that I was provided with program requirements.

I acknowledge that if I did not provide proof of income my discount is only applicable to the first visit following the date of the application. For all other visits, I will be responsible for the full fee (dependent on charges) until proof of income is submitted.

I certify that the information given above is true to the best of my knowledge.

Signature: _____

Date: _____

STAFF USE	
Reviewed By: _____	Scanned By: _____
Income Scanned: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Scale: A B C D E E1 E2 E3 E4 E5 F	<input type="checkbox"/> Patient w/Coverage Decline To Provide Info
Location/Scale: <input type="checkbox"/> 374G <input type="checkbox"/> 50G <input type="checkbox"/> EH <input type="checkbox"/> BV	<input type="checkbox"/> Branford 150 Sargent Dr. <input type="checkbox"/> Dental <input type="checkbox"/> Ryan White