Form: 2023-04

TUSCARAWAS COUNTY HEALTH DEPARTMENT
MEDICAL CLINIC
APPLICATION FOR DISCOUNT SERVICES
SLIDING FEE SCHEDULE

Public Health
Prevent. Promote. Protect.
Tuscarawas County Health Department

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical or behavioral health needs. **This information will not be used to withhold or deny services to you**.

Patient Information		
Name:	Telephone Number:	
Address:		
City:	State:	Zip:
Applicant (Guarantor) Information *If same as above complete * information only*		
*Relationship to patient: □ Self □ Parent/Guardian		
Name:		*Date of birth:
*SSN:	Telephone Number:	
Address:		
City:	State:	Zip:

1. Are you covered under Medicaid, Medicare and/or any other insurance?	□ Yes □ No
2. Have you or your family ever applied for or been denied for Medicaid or Medicare?	□ Yes □ No
3. Would you like to apply or re-apply for Medicaid or Medicare?	□ Yes □ No
4. Are you unemployed?	□ Yes □ No

Please include yourself, your spouse/partner and all dependents under 21 years of age living in the home below:

Name	Date of Birth	Relationship to Head of House	Insurance or Medicaid/Medicare?
		Head of Household	**Yes or No**
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No

If additional dependent fields are needed, please document on additional pages and attach

Please provide proof of your household **gross income** (the amount received before taxes are taken out). Household income includes ***everyone*** in the home. **Proof of income includes** most recent tax return, check stubs, a letter from the employer stating wages earned, social security award letter, perjury statement or proof of unemployment.

For Office Use Only

Employment Income	**$**	**Weekly/Bi weekly /Other Part Time / Full Time**	□ Income Verified (not required for RHW) □ Self-declared (RHW only) □ FPL: _____% □ Identification Verified □ $20 Nominal Fee (Clinical Patients Only) Patient was advised of discount rate and sliding fee scale was approved by: Staff Signature: _____ Date: _____ **PLEASE REFER TO THE CURRENT AHS SLIDING FEE DISCOUNT SLIDE SCHEDULE*
Cash Income	**$**	**Weekly /Bi weekly /Other**	
Disability	**$**	**Weekly /Bi weekly /Other**	
Social Security	**$**	**Weekly /Bi weekly /Other**	
Unemployment	**$**	**Weekly /Bi weekly /Other**	
Worker's Comp	**$**	**Weekly /Bi weekly /Other**	
Child Support	**$**	**Weekly /Bi weekly /Other**	
Other Income	**$**	**Weekly /Bi weekly /Other**	

PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify the facility. I authorize the release of any information necessary to establish my eligibility for discounted services. I understand that this application will remain in effect for one (1) year from the approval date unless income information or household size changes. It is my responsibility to report any change to the above information at my next medical visit. I understand that changes in income and/or household size may affect my discount rate.

Patient or Responsible Party Signature:_____ Date:_____