



**Public Health**  
Prevent. Promote. Protect.

Tuscarawas County Health Department

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

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 <i>If same as above complete * information only</i>			
*Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian			
Name:			*Date of birth:
*SSN:		Telephone Number:	
Address: <span style="float: right;"><input type="checkbox"/>    <input type="checkbox"/></span>			
City:		State:	Zip:
Insurance Questions			
1. Are you covered under Medicaid, Medicare and/or any other insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you or your family ever applied for or been denied for Medicaid or Medicare?			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Would you like to apply or re-apply for Medicaid or Medicare?			<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you unemployed?			<input type="checkbox"/> Yes <input type="checkbox"/> 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?
		<b>Head of Household</b>	<b>Yes or No</b>
			<b>Yes or No</b>
			<b>Yes or No</b>
			<b>Yes or No</b>
			<b>Yes or No</b>
			<b>Yes or No</b>
			<b>Yes or No</b>
			<b>Yes or No</b>

*\*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**

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

**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 Signature or Responsible Party Signature: \_\_\_\_\_ Date \_\_\_\_\_