LONG VALLEY HEALTH CENTER
EAPC/SLIDING SCALE DISCOUNT APPLICATION

In order to receive the sliding scale discount for office visits, you must document **all household** income. **Documentation** may be paycheck stub, income tax form, bank statements, or a letter from an employer. **Forms of Income** include earnings from jobs, unemployment, disability, welfare, social security, interest income, gifts and income from property. Please report any changes to income at your next visit. You have the opportunity to and may be asked to do a Medi-Cal eligibility screen. If you decline Medi-Cal coverage, you will not be eligible for Sliding Scale.

Please list family members living in the same household, including children under the age of 18.

Family Members	AGE	$ INCOME	SS#	*OFFICE USE ONLY* *ACCT#*	*CHART #*
1.					
2.					
3.					
4.					
5					
6.					
TOTAL INCOME $ _____ ☐Monthly ☐Yearly				_____ Re-certification Date	

I hereby Certify under Penalty of Perjury, that all of the information provided on this application is true and accurate, to the best of my knowledge. I understand that supplying false information on this form is a fraudulent act, under the laws of the State of California, which could result in civil or criminal penalties including fines and/or imprisonment.

I am aware I must re-certify on the date above.

_____ _____ Signature of Person Applying for Family — Date

_____ _____ Initial — Date

OFFICE USE ONLY

_____ _____ *Staff Signature* — *Date*

NOTES:

Medi-Cal SS ***YES/NO*** *For Acupuncture* ***YES/NO*** *CMSP* ***YES/NO*** *EAPC* ***YES/NO*** *Dental EAPC* ***YES/NO***	*If 65 yrs or older or PT has SSI & is under 65, check for Medicare eligibility.* *Medicare eligible? Yes ____ No_____* *Reason: _____*		

	MEDI-CAL SCREEN DONE *YES / NO*
DOCUMENTATION *YES / NO*	*Referral to Pt. Advocate Yes/No* *Date of referral ___/___/____ Reason:_____*

ELIGIBLE FOR:	$25 Discount	$35 Discount	$45 Discount	$55 Discount
Reason for denial:				