

LONG VALLEY HEALTH CENTER 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 anyone living in the same household, including couples who share household expenses, and children under the age of 18.

Family Member	AGE	\$ INCOME	SOURCE	<i>OFFICE USE ONLY</i>	
				ACCT#	CHART #
1.					
2.					
3.					
4.					
5.					
6.					
TOTAL INCOME \$ _____					
<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly					
<p>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.</p>					
_____ Signature of Person Applying for Family			_____ DATE		
_____ <i>Staff Signature</i>				_____ 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 NEEDED			MEDI-CAL SCREEN DONE		
YES / NO			YES / NO		
DOCUMENTATION			Referral to Pt. Advocate Yes/No		
			Date of referral ___/___/___ Reason: _____		
ELIGIBLE FOR:	\$15 CO-PAY	\$25 CO-PAY	\$35 CO-PAY	\$48 CO-PAY	
Reason for denial:					