Discount Fee Program

We offer affordable health care through the use of a Discount Fee Program to all patients at or below 300% of the poverty level who do not have health insurance and are not eligible for Medicaid or Medicare.

Please complete the Discount Fee Program Application form if you do not have health insurance and/or are not eligible for Medicaid or Medicare.

You are required to bring proof of identification and proof of ALL income that is received in your household.

Acceptable Types of Income Documentation:

- Paycheck stubs for most recent full month of work
- Social Security Letter
- SNAP/WIC Benefits Letter
- Prior year's federal income tax return
- Self -Employment Documentation (tax return Schedule C preferred)
- Letter from Employer
- Retirement/Pension
- Documentation of income from any other source
- If you have no income, we ask for a Letter of Support signed by the person who provides you with basic necessities.

For those uninsured individuals who apply and qualify for our Discount Fee Program, the following fees are in effect and will be collected prior to services being delivered:

Visits:

$20	New Patient visit or Physical Exam
$10	Return or Acute Visit
$5	Nurse-only visit (flu shot, blood draw, minor procedure, etc.)

Supplies & Prescriptions:

$5.00/per Rx	Processing Fee per Prescription
$5.00	Nebulizer
$2.00	Pen Needles
$5.00	Syringes

*If your income indicates that your household is at or below 138% of the poverty level, you may be required to apply for Medicaid and submit a Medicaid Denial Letter to us prior to using our Discount Fee Program.

*Application for the Program does not guarantee acceptance into the Program.

Discount Fee Program Application

***The Discount Fee Program is only available to Patients whose incomes fall at or below 300% of the Federal Poverty Line.**

How many people are in your family, including you? _____
Please list them below, with the required information for each.

Family Members: (include yourself)	Date of Birth:	Relationship	Monthly Gross Income*	Employer Name (If employed)

***If someone can claim you as a dependent on their taxes, then list all other family members on that tax return.**

Provide proof of all income received: Paycheck stubs, Retirement, Social Security, Pension, Disability, Unemployment, and ALL others not listed.

Application will be rejected if income documentation is not provided.

Employer Information	Income Information
Employer: _____ Date Employment Began: _____ Employer Phone: _____ Circle One: Full-Time Part-Time	Proof of Income: Tax Form _____ Paystubs _____ Social Security _____ Other _____ Total Household Income: _____
Unemployment Information	**Disability Information**
If Unemployed, date employment ended:_____ Does anyone receive unemployment wages? If yes, how much per month?_____	If Unemployed, has anyone applied for or received Disability? Yes / No Is anyone in your family planning on applying for disability? This includes you. Yes / No
Government Assistance Information	**Insurance Information**
Medicaid? Yes / No Who?_____ Medicare? Yes / No Who?_____ FAMIS? Yes / No Who?_____ Do you/spouse or any children under 18 receive Social Security Benefits? Yes / No	Do you or others in the family have any type of medical insurance? Yes / No Do you or others in the family have any type of prescription drug coverage: Yes / No

I certify that the information I have provided in my application is accurate and true to the best of my knowledge and belief. I do not have prescription drug coverage and authorize representatives of Brock Hughes Medical Center to share medical and financial information with other health facilities, Rx Partnership and pharmaceutical companies (or their designees) for eligibility verification and auditing purposes. I agree to inform the clinic if my household size, income, or insurance status changes. I recognize that if any information if found to be false or misleading, I will no longer receive services from Brock Hughes Medical Center.

Signature of Patient or Legal Guardian: _____ Date: _____

DO NOT COMPLETE THIS PAGE
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Family Size: _____

Income Documentation Provided: _____

_____

_____

Annual Household Income: $_____

Percent of FPG: _____

If at or below 138%, is a Medicaid Denial Letter on file at BHMC? Yes No
(If No, approval must be held in suspension until Medicaid Denial Letter is provided.)

Signature of Patient Assistance Representative: _____

Today's Date (of Approval/Denial for BHMC Discount Fee Program): _____

Reauthorization Date (12 months): _____