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

Employer: _________________________

Date Employment Began: ____________

Employer Phone: ____________________

Circle One: Full-Time   Part-Time

Income Information

Proof of Income:

Tax Form ______
Paystubs ______
Social Security ______
Other ______

Total Household Income: _____________

Unemployment Information

If Unemployed, date employment ended:__________________________

Does anyone receive unemployment wages? If yes, how much per month?_______________

Disability Information

If Unemployed, have you applied for or received Disability?   Yes / No

Are you planning on applying for disability? Yes / No

Government Assistance 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

Insurance Information

Do you have any type of medical insurance?
Yes / No

Do you 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
For Office Use Only:

Family Size: _________

Income Documentation Provided: ________________________________

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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): ___________________________