



MyCare Health Center Annual Sliding Fee Discount Schedule Application

Applicant Name (Please Print):

Date:

Application for services: Medical (MAT and Behavioral Health) Dental Both

Before beginning this application:

Please note you will need to include the below supportive documents in order for your application to be submitted for review. This information is considered private and is for MyCare Health Center use only.

If you need assistance, please notify our staff and we will be happy to help you.

All applications are valid April 1 through March 31 of the following year.

Thank You

Please check documents provided:		Please provide documentation for each area in GRAY
Patient Provided	Staff Verification	Identity: PLEASE PROVIDE ONE FORM OF IDENTIFICATION
		a. Driver's license or other government issued picture ID (if not available, see item "b." below)
		b. Social Security Card(s) or proof of legal US residency for all applicants aged 18 and over and for whom a picture ID is not available
		Income: PLEASE PROVIDE ALL THAT ARE APPLICABLE
		a. Two (2) current (less than 60 days old) pay stubs for all working household members. If no pay stubs are available, an applicant's employer may provide a letter indicating hourly wage and average hours worked per week. If a letter is provided, it must be dated within 30 days of the application date. 1040 Tax Returns are not accepted as income verification
		b. Proof of all other sources of household income (child support, worker's compensation insurance payments, unemployment insurance payments, disability payments, rental income, pension, etc.)
		c. Annual Social Security Statement of benefits
		d. Patients declaring no job and/or no income will be required to sign an <u>Income Self Declaration Form</u>
		Children: IF YOUR APPLICATION INCLUDES CHILDREN AS PART OF YOUR FAMILY SIZE
		Birth certificates for all children under 18 years of age living in the household
		Proof of Insurance: IF APPLICABLE
		Medicaid, Medicare, or other insurance card, if applicable

Please complete all sections of the application

Last Name	First Name		Middle Initial
Street Address	City	State	Zip Code
Social Security Number	Date of Birth	Age	Gender Male Female
Home Telephone	Other Telephone (please specify, cell, work or other)		
Proof of Identity – check box Driver's License State ID Other _____		Proof of Income – Please see the IDENTITY AND INCOME VERIFICATION on Page 1	
First Language – check box English Spanish Arabic Other _____		First Visit? Yes No	
Do you have any Medical Insurance Coverage? Yes or No If so, please provide your card.		Would you like assistance applying for Health or Dental Insurance? Yes No	

HOUSEHOLD SIZE/INCOME:

- What is your household (**CIRCLE ONE**) WEEKLY, MONTHLY or ANNUAL Income?
 - Income must include all cash, check or electronic sources of money used for the maintenance of your household.

	Wages	Social Security	Alimony	Disability	Unemployment	TOTAL
Yourself	\$	\$	\$	\$	\$	\$
Your Spouse	\$	\$	\$	\$	\$	\$
Other Adult	\$	\$	\$	\$	\$	\$

Other Income \$ _____ Explain source

TOTAL INCOME (**CIRCLE ONE**) WEEKLY, MONTHLY or ANNUAL: _____

- How many related individuals living in the same household are supported by this income, **please be specific (parent, grandparent, spouse)?**
- Please list any dependent minor children living in the household:
- Do you have stable housing? For this purpose, stable housing is defined as “a fixed, regular, and adequate nighttime residence in which you do not have to worry about being forced to leave unexpectedly”. **YES NO**
- Do you have a medical provider? **YES NO**
- Do you have a Dental provider? **YES NO**

APPLICANT SIGNATURE:

*I attest that the information included in this application is accurate to the best of my ability.

Please Sign:

Date:

Please complete all sections of the application

This Page for MyCare Use Only

Application Received By:	Date:
Application Approved By:	Date:
Application for services: Medical Dental Both	
Annual Household Income:	
Sliding Fee Computation:	
Supportive Documentation Used to Verify Income: _____	
Follow up Required (please be specific):	

Application Approved (Please Check Box)	YES	NO	If application denied, reason explain:
Applicant Notified: (Please Check Box)	YES	NO	
Income Updated in EHR (Please Check Box)	YES	NO	

Please use the area provided below for interview details or calculations as needed: