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 is 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 Income Self Declaration Form
		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 – circle one Driver's License ☐ State ID ☐ Other _____	Proof of Income – Please see the IDENTITY AND INCOME VERIFICATION on Page 1		
First Language – circle one English ☐ Spanish ☐ Arabic ☐ Other _____	First Visit? ☐ Yes ☐ No		
Do you have any Medical Insurance Coverage? ☐ Yes ☐ No If so, please provide your card.	Would you like assistance applying for Health or Dental Insurance? ☐ Yes ☐ No		

HOUSEHOLD SIZE/INCOME:

1. 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: _____

2. How many related individuals living in the same household are supported by this income**, please be specific (parent, grandparent, spouse)?** _____
3. Please list any dependent minor children living in the household: _____
4. 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**
5. Do you have a medical provider? ☐ **YES** ☐ **NO**
6. 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**

Family Size: _____ ALL Family MRNS: _____

_____

Annual Household Income:_____

Sliding Fee Category (if qualified):_____

Supportive Documentation Used to Verify Income:_____

Follow up Required (please be specific):_____

_____

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

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