

Date: _____

SECTION I

(Patient First Name) (Patient Middle Initial) (Patient Last Name) Patient Birth Date(mm/dd/yyyy)

Applicant Name (First, Middle initial, Last) Applicant date of birth(mm/dd/yy) Applicant relation to patient

Marital Status: Single Divorced
 Married Widow

_____ Spouse Name

Federal Grant Guidelines require us to exhaust 3rd Party payer sources before applying the Slide Discount Fee

SECTION II HOUSEHOLD INFORMATION

Please list all dependents (include yourself) **that this income supports.**

*Adults (**except for your Spouse**) listed below with zero income must provide required documentation.

Name	Age	Relationship to Applicant	Source of Income Wages, Social Security, etc...	How often are you paid? (Weekly, Bi-weekly, Monthly, Bi-Monthly)
1				
2				
3				
4				
5				
6				

Please include income documentation for each ADULT listed above.

_____ # of household members this income supports \$ _____ Total estimated gross annual income

SECTION III INSURANCE

Do you or the patient have medical/dental insurance? YES NO

If YES, Please provide a copy of the front and back of your insurance card(s) to the front desk.

SECTION IV ZERO INCOME DOCUMENTATION

You must provide ONE of the options listed below for Zero income documentation:

A. Notarized Document: You can obtain a document of ZERO income from your local clinic to have notarized.

**Adults other than spouse (18 years or over) who live in the home and whom you claim as dependents and/or occupants are also required to provide a notarized letter stating that you provide for their basic needs as stated above.

**By providing this information, you are giving us permission to contact this person for verification of the zero income status.

SECTION V APPLICANT AFFIDAVIT

I certify that the information on this application is true and accurate. I understand that it is my responsibility to complete the application and provide the required proof of income documentation in order to apply for discounted services. I understand that if I do not provide the required income documentation on my initial visit, I will be responsible for the full charges. I understand I have 60 days from my initial date of service to provide the required income documentation and receive a discount if I qualify and that no discount will be applied to accounts older than 60 days. I agree to inform Access Family Care if my financial situation changes significantly. I also understand that falsifying information or documentation on this application will result in my application being denied and any applicable discounts received under false pretenses will be revoked and I will be responsible for all charges. I understand that this application and any discount that I may qualify for apply only to the patient listed on this application. Any/all additional patients would need to apply separately.

_____ PRINT NAME OF APPLICANT

_____ SIGNATURE OF APPLICANT/ DATE

**BEHAVIORAL HEALTH
SLIDE DISCOUNT SCHEDULE 2020**

Slide Level	#1	#2	#3	#4	#5	#6
	Nominal Charge	20%	40%	60%	80%	100%
Family Size	100.000% and below	100.001-125.000%	125.001-150.000%	150.001-175.000%	175.001-200.000%	Over 200.000%
1	\$12,760	\$12,761 - \$15,950	\$15,951 - \$19,140	\$19,141 - \$22,330	\$22,331 - \$25,520	\$25,521
2	\$17,180	\$17,181 - \$21,475	\$21,476 - \$25,770	\$25,771 - \$30,065	\$30,066 - \$34,360	\$34,361
3	\$21,600	\$21,601 - \$27,000	\$27,001 - \$32,400	\$32,401 - \$37,800	\$37,801 - \$43,200	\$43,201
4	\$26,020	\$26,021 - \$32,525	\$32,526 - \$39,030	\$39,031 - \$45,535	\$45,536 - \$52,040	\$52,041
5	\$30,440	\$30,441 - \$38,050	\$38,051 - \$45,660	\$45,661 - \$53,270	\$53,271 - \$60,880	\$60,881
6	\$34,860	\$34,861 - \$43,575	\$43,576 - \$52,290	\$52,291 - \$61,005	\$61,006 - \$69,720	\$69,721
7	\$39,280	\$39,281 - \$49,100	\$49,101 - \$58,920	\$58,921 - \$68,740	\$68,741 - \$78,560	\$78,561
8	\$43,700	\$43,701 - \$54,625	\$54,626 - \$65,550	\$65,551 - \$76,475	\$76,476 - \$87,400	\$87,401

Add \$4,480 for each additional person

Based on published 2020 HHS Poverty Guidelines

Board Approved
Effective 3/1/2020
Revision Board Approved
Revision Effective

DENTAL SLIDE DISCOUNT SCHEDULE 2020

Slide Level	#1	#2	#3	#4	#5	#6
Preventive Services	Nominal Charge	20%	40%	60%	80%	100%
Basic Services	Nominal Charge	40%	50%	60%	80%	100%
Major Services	Nominal Charge	60%	70%	80%	90%	100%
Family Size	100.000% and below	100.001-125.000%	125.001-150.000%	150.001-175.000%	175.001-200.000%	Over 200.000%
1	\$12,760	\$12,761 - \$15,950	\$15,951 - \$19,140	\$19,141 - \$22,330	\$22,331 - \$25,520	\$25,521
2	\$17,180	\$17,181 - \$21,475	\$21,476 - \$25,770	\$25,771 - \$30,065	\$30,066 - \$34,360	\$34,361
3	\$21,600	\$21,601 - \$27,000	\$27,001 - \$32,400	\$32,401 - \$37,800	\$37,801 - \$43,200	\$43,201
4	\$26,020	\$26,021 - \$32,525	\$32,526 - \$39,030	\$39,031 - \$45,535	\$45,536 - \$52,040	\$52,041
5	\$30,440	\$30,441 - \$38,050	\$38,051 - \$45,660	\$45,661 - \$53,270	\$53,271 - \$60,880	\$60,881
6	\$34,860	\$34,861 - \$43,575	\$43,576 - \$52,290	\$52,291 - \$61,005	\$61,006 - \$69,720	\$69,721
7	\$39,280	\$39,281 - \$49,100	\$49,101 - \$58,920	\$58,921 - \$68,740	\$68,741 - \$78,560	\$78,561
8	\$43,700	\$43,701 - \$54,625	\$54,626 - \$65,550	\$65,551 - \$76,475	\$76,476 - \$87,400	\$87,401

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Effective 3/1/2020

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**MEDICAL
SLIDE DISCOUNT SCHEDULE 2020**

Slide Level	#1	#2	#3	#4	#5	#6
	Nominal Charge	20%	40%	60%	80%	100%
Family Size	100.000% and below	100.001-125.000%	125.001-150.000%	150.001-175.000%	175.001-200.000%	Over 200.000%
1	\$12,760	\$12,761 - \$15,950	\$15,951 - \$19,140	\$19,141 - \$22,330	\$22,331 - \$25,520	\$25,521
2	\$17,180	\$17,181 - \$21,475	\$21,476 - \$25,770	\$25,771 - \$30,065	\$30,066 - \$34,360	\$34,361
3	\$21,600	\$21,601 - \$27,000	\$27,001 - \$32,400	\$32,401 - \$37,800	\$37,801 - \$43,200	\$43,201
4	\$26,020	\$26,021 - \$32,525	\$32,526 - \$39,030	\$39,031 - \$45,535	\$45,536 - \$52,040	\$52,041
5	\$30,440	\$30,441 - \$38,050	\$38,051 - \$45,660	\$45,661 - \$53,270	\$53,271 - \$60,880	\$60,881
6	\$34,860	\$34,861 - \$43,575	\$43,576 - \$52,290	\$52,291 - \$61,005	\$61,006 - \$69,720	\$69,721
7	\$39,280	\$39,281 - \$49,100	\$49,101 - \$58,920	\$58,921 - \$68,740	\$68,741 - \$78,560	\$78,561
8	\$43,700	\$43,701 - \$54,625	\$54,626 - \$65,550	\$65,551 - \$76,475	\$76,476 - \$87,400	\$87,401

Add \$4,480 for each additional person

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