GRAND PEAKS
MEDICAL • PHARMACY
DENTAL • BEHAVIORAL HEALTH

APPLICATION FOR SLIDING FEE SCALE / DISCOUNT PROGRAM

Today Date: _____

Our Sliding Fee Scale / Discount program may reduce your cost for services at Grand Peaks Medical, Dental, Behavioral Health, & Pharmacy facilities!

Even if you have insurance, you may qualify for discounts!

MEDICAL, DENTAL & BEHAVIORAL HEALTH DISCOUNTS	***PHARMACY DISCOUNTS***
• Discounts are based on household size & income • Calculation is based on federal guidelines	• All patients are eligible for discounts • You must provide proof of income to qualify

TO QUALIFY FOR DISCOUNTS

1. Apply for the discount(s) by completing this form with your household information.
   - *Note: Medicaid patients MUST complete this form!
2. Provide proof of gross income (copies) for all family members living in the household within ***3 BUSINESS WEEKDAYS*** after the date of this application. (Gross income: income before taxes are with-held.) All income is kept strictly confidential.
   - *Note: We DO require proof of income for Medicare participants.

   To verify your income, we are required to have a copy on file of:
   - 2 Pay-stubs from those working in the household
   - **OR** Disability/Social Security payment statements
   - **OR** Most recent Federal Tax Return showing annual income (Form 1040)
   - **OR** a letter from your employer stating your wages (or a completed *Employment Verification Form*)
   - **OR** a signed letter from someone (not a family member) stating your living situation/income

HOUSEHOLD INFORMATION

HOUSEHOLD MEMBERS' NAME(S)	*DATE OF BIRTH*	*WEEKLY INCOME*	*MONTHLY INCOME*	*ANNUAL INCOME*
Head of Household:				
Spouse/Partner:				
Child/Other:				
Child/Other:				
Child/Other:				
Child/Other:				
Child/Other:				
Child/Other:				
Total calculated Annual Income:		$	$	$
Total number of family members living in your household (Working and Non-Working):				

TO COMPLETE YOUR APPLICATION FOR DISCOUNTS, PLEASE READ AND SIGN BELOW:

I understand the following:

- If your application is accepted, it will be valid for ONE year.
- I must re-apply annually and provide documentation in order to continue to receive discounted services.
- A payment is due and will be asked for/collected at the time of service.

To the best of my knowledge, the above information is true and correct. I agree to inform Grand Peaks facilities of any changes in my household size, employment or financial status. If the above information proves to be incorrect, the discount will be terminated.

_____

Signature Patient/Authorized Representative *Printed Name* *Date*

*IF YOU DO NOT WISH TO RECEIVE ANY DISCOUNTED SERVICES OR PROVIDE INCOME INFO, PLEASE SIGN:

*I DO NOT wish to provide Grand Peaks with my income. I understand I will be charged **full fees** for all services, including pharmacy/prescriptions, for each visit.*

_____

Signature Patient/Authorized Representative *Printed Name* *Date*