GRAND PEAKS
MEDICAL • PHARMACY
DENTAL • BEHAVIORAL HEALTH

APPLICATION FOR SLIDING FEE SCALE / DISCOUNTED SERVICES

*Today's Date:*_____

We offer a Sliding Fee Scale and Discount programs to our patients. These programs can reduce your cost for services in Medical, Dental, Behavioral Health, as well as our Pharmacy! Even if you have insurance, your household may qualify for discounts!

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

TO QUALIFY FOR DISCOUNTS

1. Apply by completing this form (Medicaid patients must complete this form!)
2. Provide proof of income (copies) within 3 business weekdays. All income is kept strictly confidential.
   *Note: We DO require proof of income for Medicare participants.

1. COMPLETE THE FOLLOWING TO DETERMINE ELIGIBILITY:

HOUSEHOLD MEMBERS' NAME(S)	DATE OF BIRTH	WEEKLY INCOME	MONTHLY INCOME	ANNUAL INCOME
Self:				
Spouse/Partner:				
Child:				
Child:				
Child:				
Child:				
Child:				
Child:				
Total calculated Annual Income:				

Total number of family members living in your household (Working and Non-Working):

2. PROVIDE PROOF OF HOUSEHOLD INCOME:

Grand Peaks requires proof of gross income for all family members living in the household. This information must be returned within ***3 BUSINESS WEEKDAYS*** after the date of this application. *Note: Gross income is all income before taxes are with-held.

To verify your income, we are required to have a copy on file of:

- Most recent Federal Tax Return showing annual income (Form 1040)
- **OR** 2 pay-stubs from those working in the household or Disability/Social Security payment statements
- **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

PLEASE READ CAREFULLY 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 Medical, Dental, Behavioral Health & Pharmacy of any changes in my household size, employment or financial status. If the above information proves to be incorrect, the discount will be terminated. All information is kept strictly confidential.

_____

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

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

At this time, I DO NOT wish to provide Grand Peaks Medical, Dental, Behavioral Health and Pharmacy with my income information. I understand I will be charged full fees for all services, including pharmacy/prescriptions, for each visit.

_____ _____

Signature of Applicant *Date*

ELIGIBILITY DETERMINATION: ❑Min ❑A ❑B ❑C ❑D ❑E ❑GP Employee Staff initials:_____ Rev 10/2020