VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

It is the policy of Ventura County Health Care Agency to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at the center but not those services which are purchased from outside our clinics, such as specialized diagnostic testing, X-Rays, CT Scans, MRIs, pharmaceuticals, interpretation by a consulting radiologist, dental lab work and similar services. In the hope that your economic health improves, discounts apply only to current, not future services. This form must be completed annually and/or if there are any changes. Please inquire at the front desk if you have questions.

Patient Name: _____

Date of Birth: _____ Phone Number: _____

The data gathered on this form will only be used so that we can better meet your medical, behavioral health and dental needs. This information will not be used to withhold or deny services to you. Ventura County HCA will only determine eligibility based upon your family size and income.

1. Are you covered under Medi-Cal, Medi-Care or any other insurance? Yes No
2. If insured, what is your annual deductible? $ _____

How many related people live in your household? This includes yourself, spouse, and dependents under the age of 18. _____

Income Verification

Include income from all related persons in household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans' payments, net business or self-employment income, alimony, child support, military payments, unemployment, public aid and other.

Source	**Estimated Weekly Income**	**Estimated Biweekly Income**	**Estimated Monthly Income**	**Estimated Annual Income**	**Office Use Only Section**
Annual Conv. Factor	**X 52**	**X 26**	**X 12**		I received the following income verification documents (Check all that apply /copies to be scanned with application):
Wages					Recent Pay Stub: ☐
Disability					W2: ☐
Social Security					Tax Return: ☐
Unemployment					Benefit Statement (unemployment, workers comp, Social Security): ☐
Workers Comp					Bank Statement: ☐
Family Support					Employer Letter: ☐
Rental Income					Other: _____
Other Income					
Total Income:					

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PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the family size and income information shown above is correct, and I will update the health center in the event there is a change in my income or insurance status. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

I acknowledge that I am financially responsible for all or a portion of my care, and I will be asked to provide payment at the time of service. I authorize the release of any information necessary to establish my family's eligibility for discounted services, and I give my consent to release my information to affiliated third parties involved with the discount program.

Patient Signature: _____ Date: _____

Office Use Only:

Medical Record Number: _____
Program for which the Patient Qualifies: _____
Expiration/Renewal Date: _____
Sliding Fee: ***1*** ***2*** ***3*** ***4*** ***5***

Employee Certification Statement
I certify that I asked the applicant about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant and reflects the information reported to me.

Staff Signature: _____ Date: _____

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SELF-DECLARATION OF INCOME

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

Please check and complete the following information:

I, _____, declare that I have been working and receiving cash payments in the amount of $ _____ per (check one) ____ day; ____ week;

____ bi-weekly; ____ monthly.

Name of Employer: _____

_____ I declare that I have no check stubs or other documentation to prove my earnings.

_____ I declare that I am unemployed and do not currently have any income.

I understand that any falsification or failure to report any income or changes in income may result in my being ineligible for the sliding fee scale adjustment to my charges for services.

SIGNATURE: _____ DATE: _____

For staff use only

Witness:

I witness that this patient has no documentation for the proof of income:

Print Name: _____ Date: _____

Signature of Witness _____