APPLICATION FOR REDUCED CHARGES/SLIDING FEE

MANTACHIE RURAL HEALTH CARE, INC.

Mantachie Medical Clinic – Mantachie Dental Clinic --- Mantachie Behavioral Health Clinic

Category _____% Approved ( ) Disapproved ( ) Date _____ By:_____

HEAD OF HOUSEHOLD INFORMATION

NAME_____ BIRTH DATE _____/_____/_____

ADDRESS _____

SOCIAL SECURITY # _____ PHONE_____ SEX: F_____ M_____

RACE: White____ Black/African American____ Asian ____ Pacific Islander____ More than 1 race ____ Hispanic/Latino ____

MARITAL STATUS: ___Never Married ____Married ____Separated ___Divorced ___Widowed ____Widowed ____ Common Law

EMPLOYMENT STATUS ___Full Time ____Part Time ___Student ___Disabled ____Retired ____ Unemployed

FAMILY MEMBERS

List ALL family members living in your house who are related by blood, birth or marriage.

NAME	RACE	SEX	BIRTH DATE	RELATIONSHIP	EMPLOYMENT	SOCIAL SECURITY NUMBER

PLEASE INDICATE HOW YOU ARE PAID YOUR WAGES AND YOUR GROSS AMOUNT PAID (before deductions).

	PER HOUR	WEEKLY	BI-WEEKLY	MONTHLY	BI-MONTHLY	OTHER	TOTAL
HEAD OF HOUSEHOLD	$	$	$	$	$	$	$
SPOUSE	$	$	$	$	$	$	$
OTHERS	$	$	$	$	$	$	$

INDICATE ANY OTHER HOUSEHOLD INCOME

SOCIAL SECURITY RETIREMENT	$
PENSION	$
VETERAN'S BENEFITS	$
SSI AND/OR DISABILITY	$
WORKERS COMPENSATION	$
RAILROAD RETIREMENT	$
UNEMPLOYMENT COMPENSATION	$
WELFARE AND/OR FOOD STAMPS	$
CHILD SUPPORT AND/OR ALIMONY	$
RENTAL AND/OR INTEREST INCOME	$
OTHER (Explain)	$

I certify that the above information is correct to the best of my knowledge.

_____ _____

APPLICANT'S SIGNATURE **DATE**

6/1/2015

REQUEST FOR PRIMARY HEALTH CARE UNDER FEDERAL GRANT

(Recertification is required annually)

I understand that MANTACHIE RURAL HEALTH CARE, INC., doing business as Mantachie Medical Clinic, Mantachie Dental Clinic, and Mantachie Behavioral Health Clinic, receives Federal funding under Section 330 of the U.S. Public Health Service Act to subsidize the cost of primary care health services for patients whose documented gross income is below 200 percent of the current Federal poverty level for that patient's family size.

I understand that these funds are only for patients who meet the eligibility criteria on the attached application and that are required by Federal regulations. I understand that Mantachie Rural Health Care, Inc. will certify my eligibility for these services and that documentation of this certification will be placed in my permanent patient record. I further understand that Mantachie Rural Health Care, Inc. **does not offer any free services, only a discount on the cost of services provided.**

I agree to inform Mantachie Rural Health Care, Inc. of any **substantial change in my economic status** that might affect my status. I also agree to provide updated proof of income at future visits upon request.

I understand that **Federal regulations require Mantachie Rural Health Care, Inc. to collect a minimal co-pay** for services and that I am to pay the minimal co-pay **based upon my income and family size** for each visit and that I may be asked to pay additional payments for laboratory services and for x-ray services received.

Patients with **Private Insurance or Medicare Part B Insurance** may be eligible for grant supported services and deductibles at adjusted rates; however, I understand that I will be responsible for co-payments and/or non-covered services. Such adjustments will only be applied after third party payments. I understand that:

1) I **am responsible for all charges** not covered by third party (Medicare or Private Insurance)
2) Mantachie Rural Health Care, Inc. **may refuse** future non-acute services **for non-payment**
3) Mantachie Rural Health Care, Inc. may engage a **collection agency** to collect from me for non-payment and I may be responsible for any collection fees or attorney fees to collect this debt.

I hereby certify that the income and family composition supplied on my application is true and correct. ***To receive services under this Federal Grant through falsification of information on my application may constitute a Federal offense.***

_____ _____

Signature of Applicant Date

_____ _____

Witness Date

NOTE: This application must be presented with proof of income. Acceptable proof is any of the following:

- **Last tax return**
- **Letter of award from a government agency (Social Security, Unemployment, DHHS, etc.) or your bank statement showing the amount of your government direct deposit**
- **Last W-2**
- **Most recent pay stub**
- **Letter from employer verifying wages**
- **If you have no proof of income, you may get a letter from a neighbor, family member, pastor of some other reliable source. The letter must state how they help you pay your bills.**

6/1/2015 mm