HURTT familyhealth CLINIC

Health Center Program Information for Uninsured/Underinsured Patients

The Hurtt Family Health Clinic cares about your family's health! As your medical home, we work hard to provide you with high quality, comprehensive low to no cost health care services for you and your family based on your ability to pay. We also **partner** with our families to assess and enroll our patients into many health programs offered by local, state, and federal government to give you with the best options for covering the cost of your care. *Please note that each of these programs requires certain documents and information, and we appreciate your cooperation in providing us with this information.*

The **Sliding Fee Scale Program** is based on family size and income, which is determined by the annual Federal Poverty Guidelines. Patients will be given a percentage discount based on the sliding fee scale.

To apply for any available health program, the following documentation is required:

Verification of Income: (Only one (1) of the following)

- *Current paycheck stub*
- *Tax Return*
- *Letter from employer, family, friend who are assisting with expenses*

Identification: (Only one (1) of the following)

- *Current Driver's License*
- *Government Issued Photo Identification Card*
- *School Photo Identification Card*
- *Check Cashing Photo Identification Card*

Proof of Address: (Only one (1) of the following)

- *Utility Bill with your name and address*
- *Current Driver's License*
- *Rent or lease receipt or agreement*
- *Any non-junk mail addressed to adult patient or child (under age 18) parent or guardian in the last 60 days*

As a patient of HFHC, you will be responsible for:

- Presenting all required information for any health program at the time of service
- Providing updated information on an annual basis
- Providing payment at the time of service

HFHC staff is available to help you with any questions you may have about this program and reasonable payment options that work for you. If you have questions, please call (714) 247-0300 to speak with a Call Center Staff. Please help us continue to provide health care services to all in need by paying what you can and remember ***no one will be turned away due to inability to pay***. ***We know that you have a choice when it comes to your family's medical care and we thank you for choosing Hurtt Family Health Clinic for your health care needs.***

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Sliding Fee Program Application

❒ Initial ❒ Annual Review

❒Update/Reason for Update: ❒ Income ❒ Marital Status ❒ Address ❒ Family Size ❒ Work Status ❒ Insurance Coverage

This area for office use only.

Patient's Name:	**DOB:** (mm/dd/yyyy)	**Patient is eligible for Column** _____ **of Sliding Fee Scale Table which means he/she is responsible for** _____ **of clinic charges.**
Verified with (check one box below): ☐ **State Driver's License** ☐ **Passport** ☐ **SS Card** ☐ **VISA** ☐ **Green Card** ☐ **OTHER:** _____	**Birthplace:** (CITY/STATE/COUNTRY)	
Guardian's Name:	**Relationship to Patient:**	
Address: (Check Method Verified by: ☐ State Issued Driver's License ☐ Utility Bill ☐ Lease/Rental Agreement)		
Home Phone:	**Cell Phone:**	

Number of PEOPLE living in your household? (Write only family members who are responsible for each other i.e. spouse, dependent children, and the parents of the children).

NAME:	**AGE:**	**SS #:**
NAME:	**AGE:**	**SS #:**
NAME:	**AGE:**	**SS #:**
NAME:	**AGE:**	**SS #:**

Patient's Gross Income: ☐ **Month** ☐ **Year**	**Spouse's Gross Income:** ☐ **Month** ☐ **Year**	**Total Household Gross Income:** ☐ **Month** ☐ **Year**

Source of Income: ☐ **Employment** ☐ **Self-Employed** ☐ **Unemployment** ☐ **Disability** ☐ **Social Security Benefits** ☐ **Supplemental Security Income** ☐ **Child Support** ☐ **Family Member or Friend Supporting Patient** ☐ **Other:** _____

What was used to verify income? ☐ **Pay Stubs** ☐ **Tax Forms** ☐ **Other (specify)** _____

☐ **I am unable to provide Proof of Income AND I certify that this is my HOUSEHOLD INCOME, to the best of my knowledge:**

_____

_____

By signing below, I acknowledge that the sliding fee scale program is not a health insurance but an internal program for our patients who do not have insurance and are not eligible for public health insurance.

Regarding discounts on services, I am aware of the following:

1) **Discounts for Medical and Prescription Health Services are based on household income. All supporting documents must first be provided in order for application to be considered.**
2) **Discounts will be applied to services rendered according to date application was received, provided all necessary documentation is included within 30 days from the date of the application.**
3) **In order to continue to remain on this program, I am aware that I must apply annually.**

☐ **I agree that all of the above information is true to the best of my knowledge. Giving false information or by not submitting supporting documents within 30 days of my visit to the health center will result in my application being dismissed.**

☐ **I decline to participate in the Sliding Fee Scale Program.**

Patient/Parent or Guardian Signature:	**Relationship to patient:**	**Date:**
Received by HFHC Staff:		**Date:**