APPLICATION FOR DISCOUNT SERVICES

PATIENT INFORMATION	
Patient Name:	Date of Birth:
Sex Assigned at Birth: ❑ Male ❑ Female	Gender: _____ ❑ Prefer not to say
Race: ❑ White ❑ Black/African American ❑ Multi-Racial ❑ American Indian/Alaska Native ❑ Hispanic ❑ Asian ❑ Pacific Islander ❑ Native Hawaiian ❑ Other _____	
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino	
Home Address:	
City, State	Zip Code:
Phone Number:	
APPLICANT (GUARANTOR) INFORMATION ❑ *If same as above check this box and proceed to question #1.*	
Relationship to Patient: ❑ Self ❑ Parent/Guardian	
Name:	Date of Birth:
SSN:	Phone Number:
Home Address:	
City, State	Zip Code:
1. Are you covered under Indiana Medicaid, Medicare and/or any other insurance? ❑ Yes ❑ No	
2. If you have private insurance, what is your out-of-pocket expense? $_____	
3. Have you or your family ever applied for or been denied for Indiana Medicaid or Medicare? ❑ Yes ❑ No	
4. Would you like to apply or re-apply for Indiana Medicaid today? ❑ Yes ❑ No	
5. Are you unemployed? ❑ Yes ❑ No	
6. Are you too sick to work or are you disabled? ❑ Yes ❑ No	

Please include yourself, your spouse/partner and all dependents under 21 years of age living in the home below:

Name	Date of Birth	Relationship to Head of Household	Indiana Medicaid or Private Insurance
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

INCOME VERIFICATION

Please enter your **gross income** (the amount received before taxed are taken out). Household includes everyone in the home. **Proof of income includes:** most return tax return, check stubs, a letter from the employer stating wages earned, perjury statement or proof of unemployment.

If there is **no income to report**, please bypass the income table and proceed to the next step.

Employment Income	$	Weekly/Biweekly/Other (please circle one) Part Time/Full Time (please circle one)	*Office Use Only* ❑ Income Verified ❑ Identification Verified FPL: _____ Staff Signature: _____ Date: _____ Patient Advised of Discount Rate: ❑ Yes _____ (staff initials) Enrollment Dates: _____ to _____ Approved by: _____ Date: _____ ***Please Refer to the current Damar Health Services Sliding Fee Discount Fee Schedule.**
Cash Income	$	Weekly/Biweekly/Other (please circle one) Part Time/Full Time (please circle one)	
Disability	$	Weekly/Biweekly/Other (please circle one) Part Time/Full Time (please circle one)	
Social Security	$	Weekly/Biweekly/Other (please circle one) Part Time/Full Time (please circle one)	
Unemployment	$	Weekly/Biweekly/Other (please circle one) Part Time/Full Time (please circle one)	
Worker's Compensation	$	Weekly/Biweekly/Other (please circle one) Part Time/Full Time (please circle one)	
Child Support	$	Weekly/Biweekly/Other (please circle one) Part Time/Full Time (please circle one)	
Other Income	$	Weekly/Biweekly/Other (please circle one) Part Time/Full Time (please circle one)	

PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify Damar Health Services. I understand that I will be financially responsible for **all or a portion of my care** and that I will be asked to **submit payment at the time of service**. I authorize the release of any information necessary to establish my eligibility for discounted services and I give my consent to release my information to insurance companies for auditing purposes.

Patient Signature: _____ Date:_____

Declination Statement (for Patient's Who Do Note Want to Comply with Slight Scale Requirements

Because you do not wish to apply for our sliding scale discount, you are choosing to be a self-pay patient. This means that you will be responsible for any and all balances due after the self-pay discount. Office and lab changes are not applicable, and you will not be allowed to receive a discount for these charges.

Patient Signature: _____ Date: _____

Complete Below for Self-Declaration of Income

Please complete the information below only *if you have no other way to document your income.* All of the boxes below must be checked, and all the questions answered. Failure to complete this information will result in the denial of your application for a sliding scale discount.

❑ I get paid cash.
❑ I do not get paychecks/pay stubs.
❑ I cannot get a letter from my employer. Explain why: _____
❑ I do not have access to my financial information, Explain why: _____

Patient Certification Statement

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the Damar Health Services Sliding Fee Discount Schedule. I understand that Damar Health Services employees may verify my information on this form.

Patient Signature: _____ Date: _____

Employee Certification Statement

I certify that I asked the applicant/recipient about all the 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/recipient and reflects the income the applicant reported to me.

Employee Signature: _____ Date: _____