Complete
Family Medicine
A service of Hannibal Regional

Please Read

You MUST provide ONE of the following documents for each source of income in the household (adults only) with your completed application in order to apply for the sliding scale:

- ❏ Prior year W-2, 1099, or most recent tax returns
- ❏ Two most recent pay stubs
- ❏ Letter from employer
- ❏ Form 4506-T (if W-2 not filed)

If all of the required documents are not submitted *within two weeks* of the date of the application, your application will be **denied** and you will be billed the full price for all charges.

Please call 660-665-7575 with questions.

If you cannot provide the above documents, you will be required to submit the self attestation form for the missing documents (see last page of application). Incomplete applications will not be processed.

Date Given:_____
Due Date:_____
(Due 2 weeks from the date given.)

Sliding Fee Discount Application

It is the policy of Complete Family Medicine to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual household income. Please complete and return the application to the front desk within two weeks of the date you received the application to determine if you or members of your family are eligible for a discount. If you have insurance, it will still be billed unless we are notified otherwise.

The Sliding Fee Discount Program will only be made available for outpatient clinic visits (office visits, laboratory, and imaging services), but not those services, supplies, or equipment that are purchased from outside, including, but not limited to, reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. Discounted services would apply effective the date of application approval going forward.

This form must be completed every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD		PLACE OF EMPLOYMENT		
STREET (HOME ADDRESS)	CITY	STATE	ZIP	PHONE NUMBER
Name of Insurance		Group Number		Member ID Number/DCN Number

Please complete all applicable fields. Please list spouse and dependents under age 18.

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
HEAD OF HOUSEHOLD		DEPENDENT (under 18 years old)	
SPOUSE		DEPENDENT (under 18 years old)	
DEPENDENT (under 18 years old)		DEPENDENT (under 18 years old)	
DEPENDENT (under 18 years old)		DEPENDENT (under 18 years old)	

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc				
Income from business, self-employment, and dependents				
Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

Applicants MUST provide ONE of the following documents for each household member with an income source before the application is reviewed.

- ❑ ***Prior year's W-2 (or tax returns)*** **or 1099 form**
- ❑ ***Two most recent pay stubs.*** **(Please see policy if self-employed or homeless.)**
- ❑ **Letter from employer**
- ❑ **Form 4506-T (if W-2 not filed)**

I certify that the family size and income verification shown above is correct.

Name (Print)	Date of Birth
Signature	**Date**

OFFICE USE ONLY BELOW THIS LINE

Approved _____ Denied _____

Approved Discount: _____

Approved By: _____

Date Approved/Denied: _____

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Sliding Scale Self-Attestation Form

Explanation as to why one of the required financial verification forms (eg - W-2, 2 most recent pay stubs, letter from employer, or Form 4506-T if W-2 not filed) is not attached to sliding scale application:

Please provide additional information that might help us get a better understanding of your financial circumstances, specifically related to how you are currently covering your expenses if you do not have a job or steady source of income listed.