



**INCOME-BASED PAYMENT PROGRAM (Sliding Fee)**

Please list all persons (including yourself) in your home:

<u>Name</u>	<u>Social Security</u>	<u>Birthdate</u>
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

**Any additional family members & information may be put on another sheet & attached**

**Address:**

**Telephone Number:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Is any person in your household employed? YES or NO

If YES, Who is employed? \_\_\_\_\_

Employer's name: \_\_\_\_\_

Salary? \$ \_\_\_\_\_ per wk/mo/yr. (Documentation Required).

Do you have insurance through your employer? YES or NO

If YES, Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_

Does a household member receive any of the following benefits?: SSI, Social Security, Child Support, Alimony, Worker's Comp., Unemployment, Pension, Annuity, Other: \_\_\_\_\_?

Amount Received? \$ \_\_\_\_\_ per wk/mo/yr.

**NOTICE - REDUCED CHARGES ARE TO BE PAID AT THE TIME OF THE OFFICE VISIT.**

The above information is true and correct to the best of my knowledge. I grant the Lewis County Primary Care Center, Inc. permission to verify the above information from all available sources. I agree to notify the Lewis County Primary Care Center, Inc. if there are any changes in my financial situation.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

Interviewer \_\_\_\_\_ Executive Director \_\_\_\_\_

Amount of Discount approved \_\_\_\_\_ % Patient Pays \_\_\_\_\_ %

Acct # \_\_\_\_\_ Income \_\_\_\_\_ Card \_\_\_\_\_ File noted \_\_\_\_\_ Adj Made \_\_\_\_\_



**INCOME-BASED PAYMENT PROGRAM (Sliding Fee)**

Lewis County Primary Care Center doing business as PrimaryPlus offers a payment program based on your household income and number of family members.

The reverse is a **SLIDING FEE APPLICATION**. \*\*\*\*\*Please complete and return with proof of **ALL** household income. **FAILURE TO PROVIDE PROOF OF ALL INCOME WILL DELAY PROCESSING**. \*\*\*\*\*

**Acceptable forms of income include:**

- Recent paystubs
- Unemployment statements
- SSI/SSA award letters
- Tax returns
- Pension or Workers' Compensation documentation

**If you have no income or work odd jobs, please supply the following:**

- Denial letter from Dept. of Health & Human Services
- Denial letter from K-Chip
- Denial letter from Medicaid
- Letter for Food Stamps (all pages).

Please bring this documentation to our front desk clerk and we will be happy to make copies – we do not wish to keep originals on file.

If qualified, you are eligible for a discount ranging from **25% to 75% on all Medical Services** and a discount ranging from **25% to 50% on all Dental Services** offered at the center (co-pays, all injectable medications, medical equipment, etc. **are NOT ELIGIBLE** for discount.)

However, once approved, to remain eligible **YOU MUST MAKE EVERY EFFORT TO PAY YOUR PORTION ON THE DAY THAT SERVICES ARE PROVIDED**. Please be prepared to make a payment at the time of checkout. Failure to comply with this requirement will make your application **VOID**, therefore making you ineligible for further discount.

Sliding fee applications **must be updated on an annual basis**, or sooner, if your household income changes.

Please feel free to call our Patient Services Department should you have any questions concerning your application. **PLEASE RETURN COMPLETED APPLICATION TO ANY PRIMARYPLUS LOCATION OR MAIL TO:**

**PrimaryPlus Sliding Fee Scale  
P.O. Box 550  
Vanceburg, KY 41179**

I have read the above and I understand its content and significance.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**THANK YOU**

**(APPLICATION ON THE REVERSE SIDE)**