Lifecare
Family Health & Dental Center

(Sliding Fee) Reduced Rate Application
RRA 2018-04

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Date of Assessment: _____

Family Size

Family size definition: Members of your family listed below, that you support.

Family Size (household): The household is considered to be the legal spouse of the patient and/or legal dependents. Households are also inclusive of unmarried couples, grandparents raising children, and nontraditional family units living in the same house.

Please list all family (household) members, including yourself (if applicable).

Name	Social Security #	Date of Birth	Relationship

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Household Income

Family income definition: All income your family members receive. Patients will be required to provide documentation such as Proof of Income, as defined below; Proof of Identity; and Proof of Residency.

This includes:

- Gross Wages, Salaries, and Tips, Unemployment Compensation, Business or Farm Income (net profit or loss), Sick Pay, Strike Pay, Annuity Plan that is paying an individual, Sheltered Workshop Earnings, Pensions, Social Security Benefits (both retirement and disability), Military Pay, Rental Income, Royalties, Partnership, S-Corp, Capital Gains, Dividends, Alimony, Other Income (e.g. gambling, lottery and hobby income)

Required Documentation includes any of the following:

- Federal income tax return
- Pay Stubs (at least the last 2 paystubs per working household member)
- Employer Letter Verifying Employment (Only if paid in cash)
- Unemployment Benefit Summary Letter (Only if collecting unemployment)
- Social Security or Disability Benefits Verification
- Statement of Retirement Income
- Department of Public Assistance documentation
- Any other official documentation stating income

A self-declaration form will be used if the patient has no proof of income.

Please list all sources of income (monthly) for each family member:

Source of Income	Self	Spouse	Family Member(s)	Total
Gross Wages, Salaries, Tips, etc.				
Railroad retirement, Pension, Annuity Plan, Military Pay, Social Security Benefits				
Income from Business or Farm				
Other (from above List)				
Total Monthly Income				

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Patient Name: _____ Date of Birth: _____

Date of Assessment: _____

The information I have provided concerning the size of my family and my family's annual income from all sources is true, accurate, and complete to the best of my knowledge. I have given this information for the purpose of determining my family's eligibility for reduced rates for services provided by Lifecare Family Health & Dental Center, Inc.

I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the State of Ohio.

I agree to report any change in either my income or my family size to Lifecare before or at the time of my next contact or any contact by any family members. I know that the information I have given will continue to be relied upon until it is changed.

I understand that I must complete a new Reduced Rate Application. Patients already receiving reduced rates are required to reapply before the expiration date of the existing discounts. Each Reduced Rate Application expires one year from date of approved initial or renewed application date. The patient will be evaluated for eligibility on the scale (Federal Poverty Guidelines) in effect at the time of evaluation. If Lifecare has reason to suspect that the information I have given is untrue, inaccurate, or that I have not properly reported changes, Lifecare may initiate a review of my status and I will authorize access to all my financial records. If I refuse an authorization, Lifecare will no longer discount my families account.

I understand that Reduced Rates apply only to services provided by Lifecare. The Reduced Rate will not apply to services received from other entities other than Lifecare. The reduced rate does not apply to services performed by labs, hospitals, or other entities, or to prescriptions.

I understand that if eligible for reduced rates, I will be expected to pay the associated fee at the time of each office visit.

My signature below indicates that all information I have provided is true to the best of my knowledge.

I have received notification of my Reduced Rate Discount.

Annual Gross Income_____Number of Dependents, including Applicant: _____

Tier Determination: _____Start Date: _____End Date: _____

Applicant's Signature: _____Date: _____

Witness Signature: _____ Date: _____

Revised June 7, 2021

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Financial Agreement

I hereby consent to all treatment deemed necessary by the staff of Lifecare Family Health & Dental Center, Inc. I authorize the Lifecare Family Health & Dental Center, Inc. (LIFECARE FHDC) to use, disclose, and/or receive any or all information relating to my treatment. My provider may contact any other covered entity that has provided services to me for the purpose of obtaining further diagnosis.

LIFECARE FHDC has made prior arrangements with many health plans to accept direct payments. LIFECARE FHDC will bill those plans for which it has made prior arrangement and will only require you to pay the authorized Co-pay at the time of service. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services.

I hereby authorize release of information necessary to file a claim with my insurance company and **assign benefits, otherwise payable to me, to the physician or group indicated on the claim**. I am responsible for any referrals and/or authorizations required by my insurance company. I understand I am financially responsible for any balance not covered by my insurance. My insurance policy, if applicable, is a contract between me and my insurance company. LIFECARE FHDC is not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim.

As a courtesy to the patient, LIFECARE FHDC will submit claims to any insurance company. If the patient's coverage is with a plan that LIFECARE FHDC does not have prior arrangement, the charges for the patient's care and treatment are the patient's responsibility and due in full at the time of service.

LIFECARE FHDC offers reduced rates to qualifying uninsured patients. I understand that unless other arrangements have been made in advance by either myself or my health coverage provider, **payment is due at the time of service**. For all services rendered to minors, the custodial parent or legal guardian will be responsible for all charges.

For the patient's convenience LIFECARE FHDC will accept Visa, MasterCard, Cash, and Personal Check. **There will be a $10.00 fee charged to patients for all non-sufficient funds checks and the patient will be required to pay cash for all future visits.**

I understand that LIFECARE FHDC is not in the business of extending credit and I agree to pay the above practice at the time its bill is presented. If prompt payment is not made, LIFECARE FHDC will take action to collect its charges. In extreme cases of non-payment, LIFECARE FHDC reserves the right to dismiss the patient from the practice.

I UNDERSTAND THAT THERE MAY BE CHARGES IN ADDITION TO MY COPAY. I AGREE TO PAY SAID CHARGES.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Lifecare
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Self-Declaration of Income and Family Size

For Reduced Rate Program

Patient Name: _____Date of Birth____/____/____Last 4 digits of SS#_____

I hereby attest that;

My family income for the past (12) months has been: *_____

My family income for the past (3) months has been: *_____

My family income for the current month has been: *_____

***If family income is/was zero, please briefly explain how your household was maintained:**

Family Size

Please list all family members and dependents you support, to be included in the Reduced Rate Application.

Name	Social Security #	Date of Birth	Relationship
			SELF

I am signing this statement under penalty of perjury which means I've provided true answers to the statements above, to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.

Patient Signature: _____Date: _____

Witness:_____Date: _____