# Rehabilitative Health Services Clinic
# Healthcare Discount Fee Policy

## Discount Application Process

A completed application including required documentation of the home address, household income, and insurance coverage must be on file and approved by the billing office before a discount will be granted. If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required.

Adolescent patients seeking confidential care are exempt from the application process, and services are provided at the nominal rate.

| | |
|---|---|
| **Medical** | The discount is applied to all in-office services and off-site services supplied by RHS Clinic Healthcare providers. |
| **Pharmacy** | Samples are provided, when available, without charge |
| **Lab** | The discount is applied to in-office lab draws. Reference laboratory tests and consulting interpretations are excluded. |

## Services Covered and Excluded

## Rehabilitative Health Services Clinic
## Discounted/Sliding Fee Application

It is the policy of Rehabilitative Health Services Clinic, to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

### Services Covered and Excluded

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist or other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. Approved applicants will need to complete a SFS application and re-apply

for the sliding fee discount every 6 months. Please inquire at the front desk if you have questions.

Number of related persons living in your household: __________

| Household Member | Household Income (complete one column) | | |
|---|---|---|---|
| | **Annual** | **Monthly** | **Bi-Weekly** |
| **Self** | | | |
| **Spouse** | | | |
| **Dependent Children under age 18** | | | |
| **Total** | | | |

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment, and public aid.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print) ___________________________ Signature___________________

Date __________________________________

**Office Use Only**

**Patient Name** ____________________________ **Discount** ____________________

**Date of Service**___________________________ **Approved by** _________________

## REHABILITATIVE HEALTH SERVICES CLINIC
## FAMILY ASSISTANCE PLAN APPLICATION

<table>
<tr><td colspan="3">NAME OF HEAD OF HOUSEHOLD</td><td colspan="3">PLACE OF EMPLOYMENT</td></tr>
<tr><td>STREET</td><td>CITY</td><td>STATE</td><td>ZIP</td><td colspan="2">PHONE</td></tr>
<tr><td colspan="3">HEALTH INSURANCE PLAN</td><td colspan="3">SOCIAL SECURITY NUMBER (OPTIONAL)</td></tr>
</table>

**PLEASE LIST SPOUSE AND DEPENDENTS UNDER AGE 18**

| NAME | DATE OF BIRTH | NAME | DATE OF BIRTH |
| --- | --- | --- | --- |
| SELF | | DEPENDENT | |
| SPOUSE | | DEPENDENT | |
| DEPENDENT | | DEPENDENT | |
| DEPENDENT | | DEPENDENT | |

**ANNUAL HOUSEHOLD INCOME**

| SOURCE | SELF | SPOUSE | OTHER | TOTAL |
|---|---|---|---|---|
| GROSS WAGES, SALARIES, TIPS, ETC. | | | | |
| SOCIAL SECURITY, PENSION, ANNUITY, AND VETERAN'S BENIFITS | | | | |

| Source | Self | Spouse | Other | Total |
|---|---|---|---|---|
| Alimony, child support, military family allotments | | | | |
| Income from business self employment, and dependents | | | | |
| Rent, interest, dividend, and other income | | | | |
| **TOTAL INCOME** | | | | |

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (print) ______________________________ Date _________________

Signature _________________________________

**OFFICE USE ONLY**

Patient name________________________________________ Date _______________________

Date of Service ______________________ **Approved** by ______________________________

| Verification Checklist (attach copies) | YES<br>X | NO<br>X |
|---|---|---|
| Identification/Address: Driver's license, utility bill, employment ID | | |
| Income: Prior year tax return, three most recent pay stubs, or other | | |
| Insurance: Insurance card(s) | | |
| Medicaid: Application or evidence of rejection | | |