Cabarrus Rowan Community Health Centers, Inc.

Cabarrus Rowan Community Health Centers, Inc.

Sliding Fee **DISCOUNT PROGRAM** Application

Patient Name: _____ DOB: _____ Date: _____

☐ I have been given the opportunity to apply for the CRCHC Sliding Fee Scale Program, and I decline the opportunity to apply for the CRCHC Sliding Fee Discount Program.

Patient Signature (or Guardian) _____ Date: _____

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical and behavioral health needs.

1. Are you covered under Medicaid, Medicare or any other insurance? _____Yes _____No
2. Would you like assistance applying or re-applying for Medicaid? _____Yes _____No
3. Are you employed? _____Yes _____No

Completed by patient/guardian: Please include yourself, spouse, partner, children, and anyone else living in home

Name	Relation	DOB	Income	Frequency	Proof of Income	Health Insurance Plans you are covered by

I understand the information I provide is subject to verification by CRCHC. I agree the above information is true and correct to the best of my knowledge. I understand that providing false information can result in me being denied ability to apply for the discount program, ,furthermore, I agree to adhere to all terms and conditions of the Sliding Fee Discount Fee Discount Program. I will report any changes of the above information to CRCHC.

I understand that if I am applying for financial assistance and do not have any source of income or do not have proof of income with me today, CRCHC will discount my services for today based on estimated income. **However, I will be totally responsible for any subsequent visits at CRCHC, if I do not bring proof of income within 10 days.**

_____ _____ _____

Patient/Guardian Signature | Printed Name | Date

_____ _____ _____

Staff Name | % Approved | Date