Discount Program Application

It is necessary to ask you for personal and household financial information in order to see if you qualify for discounted medical and dental services. We will not share your information with other agencies unless it is necessary for care coordination. All discount cards expire six (6) months from the date you complete the application, unless otherwise specified. At that time, we will ask you to again verify your current income and number of related related household members in order to receive discounts on your medical and dental services.

Please note: All of the **Information Needed to Apply** must be presented at the time of your screening appointment to be considered for the Discount Program. If you are missing any of this information, you will be required to set up a new screening appointment.

Salina Family Healthcare Center
The Heart of Compassionate Healing & Education

651 E Prescott · Salina, KS 67401
Medical: (785) 825-7251
Dental: (785) 826-9017

Please call 785-825-7251 to schedule a financial screening appointment. Applications that are mailed in WILL NOT be processed.

Information Needed to Apply

- One month proof of income for all related household members. (**See instructions below**)
- Photo ID or birth certificate for all related household members
- Prior year tax return
- Medicaid denial letter if pregnant or under 19

TO BE COMPLETED BY APPLICANT:

Applicant Name: _____ **Today's Date:** __ __ / __ __ / __ __ __ __

Address: _____ **Social Security #:** __ __ __ - __ __ - __ __ __ __

City, State, Zip: _____ **Date of Birth:** __ __ / __ __ / __ __ __ __

County: _____ **Phone Number:** __ __ __ - __ __ __ - __ __ __ __

Household Income

Household income includes ALL income for ALL related household members (related household members includes relation by blood or by marriage).

Please circle all that apply to your household and *provide one current month proof of each of the circled items.*

Wages	Unemployment
Social Security	Retirement Income
Alimony	Student Loans
Child Support	Tips or Commissions
Disability	Cash Assistance
Self Employment	Food Stamps
Interest Income	Other: _____

How many related household members live with you? _____
(Include spouse, children, aunts, uncles, cousins, in-laws, etc.)

Is anyone in the household pregnant? Yes No

Office Use Only

Total number in household: _____ Screener Signature: _____

Annual household income: _____ Date: _____

Level: B C D E F

Effective 01/01/2010

Continued →

Household Members

Fill in all information for you and all related family members living in your house. Complete one information box for each related household member.

Name	Relationship	Birth Date	Language	Social Security Number	Gender (Circle)
	Self				M F

Employer

(Office Use Only)
☐ Rx ☐ MCR
☐ MCD ☐ DENT
☐ MED ☐ NONE
☐ HOLD

Are you:

a Seasonal Farmworker?	Y	N
a Veteran?	Y	N
of Hispanic, Latino, or Spanish orgin?	Y	N

Do you have:

a Social Security #	Y	N
Medical Insurance	Y	N
Dental Insurance	Y	N
Medicare	Y	N
Secondary Insurance	Y	N

Circle your race:

Asian	Other Pacific Islander
Native Hawaiian	Black/ African American
White	American Indian/Alaskan Native
More than one race	Other: ____________________

Name	Relationship	Birth Date	Language	Social Security Number	Gender (Circle)
					M F

Employer

(Office Use Only)
☐ Rx ☐ MCR
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☐ HOLD

Is this person:

a Seasonal Farmworker?	Y	N
a Veteran?	Y	N
of Hispanic, Latino, or Spanish orgin?	Y	N

Does this person have:

a Social Security #	Y	N
Medical Insurance	Y	N
Dental Insurance	Y	N
Medicare	Y	N
Secondary Insurance	Y	N

Circle this person's race:

Asian	Other Pacific Islander
Native Hawaiian	Black/ African American
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Continued →

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Continued →

Discount Program Application

- Our Sliding Fee Discount Program is designed to help you pay for services provided by Salina Family Healthcare Center. These services include medical, dental, and mental health.

- Discount Program cards are good for six (6) months from the date on the face of the application, unless otherwise specified. This application is based on poverty guidelines provided annually by the U.S. Government. You must complete a new application every six months, or as otherwise required by Salina Family Healthcare Center, even if your household size or income has not changed. The Information Needed to Apply must be provided each time you reapply for the program.

- **If your household size or income changes in any way within the six month period that your card is effective, it is your responsibility to notify us. You will be asked to reapply at that time.**

- We can only apply Sliding Fee discounts to services given by providers of Salina Family Healthcare Center. We cannot discount charges from hospitals, ambulance services, or physicians outside of Salina Family Healthcare Center. Lab tests and prescription medications ordered by outside physicians can not be discounted. Hospital procedures are not subject to discounts, but hospital admit, follow-up visits, and dismissal charges by Salina Family Healthcare Center providers are eligible for Sliding Fee discounts. We cannot discount other services that you may receive while in the hospital, such as radiology, prescriptions, laboratory, and any other service not *directly* provided by one of the physicians of Salina Family Healthcare Center.

- In-house procedures that are elective/non-preventative are not eligible for Sliding Fee discounts. Elective/non-preventative procedures are routinely denied by Medicare, Medicaid, and Private Insurance as they are not considered medically necessary. Examples of elective/non-preventative procedures include tattoo removal, piercing, cosmetic surgery, acupuncture, ER visits, MRI testing, etc. Please check with our business office before your appointment if you have questions regarding coverage of your procedure.

- By signing below, I affirm the statement of household size and income is true and accurate, and that all statements made by me in this application are true.

- I understand
    - Fees are due at the time of service.
    - I am financially responsible for the full price of procedures that are elective/non-preventative.
    - I am responsible for inquiring about the coverage of services with the business office prior to treatment, not with the provider at the time of treatment.
    - The Discount Program card is not an insurance card.
    - I must reapply for the discount program every six months, and it is my responsibility to remember when this is due.
    - I am responsible for informing Salina Family Healthcare Center of any changes in my household size or income. Failure to do so may result in loss of discount eligibility for up to one year.
    - If I qualify for the discount program, I will receive a card in the mail along with a benefit explanation sheet.
    - If I do not qualify for the discount program, I will be notified by mail. I am still welcome to be a patient at Salina Family Healthcare Center, but will be responsible for the full price of services provided to me.

Salina Family Healthcare Center reserves the right to verify any information presented, either through a third party or through the request for additional information from the applicant. Fraudulent information given during the financial screening process is grounds for dismissal from this practice and Salina Family Healthcare Center will prosecute to the fullest extent of the law. The Office of the Attorney General may be contacted regarding fraudulent information, behavior, or misrepresentation, per federal mandate. **By signing below, I acknowledge that I have read the above information, and that all information I have provided on my Discount Program Application is true.**

Signature: _____ Date: _____

Screener Signature: _____