SALINA FAMILY HEALTHCARE CENTER

Medical 785-825-7251 | Dental 785-826-9017 | Pharmacy 785-452-3900 | Main Office 785-825-7251

Discount Program Application

See if you can pay less for our services:
Please call 785-825-7251 to schedule a financial screening appointment. Do not mail your application.

We designed our Discount Program to help you pay for the services you get at Salina Family Healthcare Center. We discount medical, dental, pharmacy, eye care and mental health services. We have to ask you for household income to see if you can pay less for your services. We will not share your information with other places unless we have to for your health care. Discount cards expire 12 months from the approval date unless we tell you otherwise. After it expires, you have to apply again.

You must bring all of the information needed to apply to your screening appointment. You will be required to set up a new screening appointment if you do not have everything at your first appointment.

What you will need to apply:

- One-month proof of income for all family members who live in the house (pay stubs)
- Photo ID or birth certificate for all related family members who live in the house
- Last year's tax return
- Insurance ID cards

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 money made by all family members who live in the house. Family members includes relation by blood or by marriage. Any adult that cannot give proof of income must sign an IRS form to request a summary of last year's tax return. A financial screener will help you complete the IRS form during your appointment.

Please circle all that the family members in your house get.

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

How many family members live in the house? _____
(Include spouse, children, aunts, uncles, cousins, in-laws, etc.)

Is anyone in the house pregnant? Yes No

Office Use Only
Total number in household: _____ Date: _____
Annual household income: _____ Level: B C D E F
Screener Signature: _____

PEOPLE WHO LIVE IN THE HOUSE

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

Legal Name:			Relationship: SELF
Preferred Name:			Language:
Date of Birth: / /		Social Security #: - -	
Assigned sex at birth: ❑ M ❑ F ❑ Choose not to disclose ❑ Unknown			
Preferred Pronouns: ❑ He/him ❑ She/her ❑ They/them			Office Use Only: ❑ RX ❑ MCR ❑ MCD ❑ DENT ❑ MED ❑ EC ❑ NONE ❑ HOLD ❑ SEC
Employer:	Are you a seasonal farmworker? ❑ Yes ❑ No	Are you a Veteran? ❑ Yes ❑ No	
Do you have: Medical Insurance ❑ Yes ❑ No Dental Insurance ❑ Yes ❑ No Vision Insurance ❑ Yes ❑ No		Do you have: Medicare ❑ Yes ❑ No Secondary Insurance ❑ Yes ❑ No	

Legal Name:			Relationship:
Preferred Name:			Language:
Date of Birth: / /		Social Security #: - -	
Assigned sex at birth: ❑ M ❑ F ❑ Choose not to disclose ❑ Unknown			
Preferred Pronouns: ❑ He/him ❑ She/her ❑ They/them			Office Use Only: ❑ RX ❑ MCR ❑ MCD ❑ DENT ❑ MED ❑ EC ❑ NONE ❑ HOLD ❑ SEC
Employer:	Is this person a seasonal farmworker? ❑ Yes ❑ No	Is this person a Veteran? ❑ Yes ❑ No	
Does this person have: Medical Insurance ❑ Yes ❑ No Dental Insurance ❑ Yes ❑ No Vision Insurance ❑ Yes ❑ No		Does this person have: Medicare ❑ Yes ❑ No Secondary Insurance ❑ Yes ❑ No	

Legal Name:			Relationship:
Preferred Name:			Language:
Date of Birth: / /		Social Security #: - -	
Assigned sex at birth: ❑ M ❑ F ❑ Choose not to disclose ❑ Unknown			
Preferred Pronouns: ❑ He/him ❑ She/her ❑ They/them			Office Use Only: ❑ RX ❑ MCR ❑ MCD ❑ DENT ❑ MED ❑ EC ❑ NONE ❑ HOLD ❑ SEC
Employer:	Is this person a seasonal farmworker? ❑ Yes ❑ No	Is this person a Veteran? ❑ Yes ❑ No	
Does this person have: Medical Insurance ❑ Yes ❑ No Dental Insurance ❑ Yes ❑ No Vision Insurance ❑ Yes ❑ No		Does this person have: Medicare ❑ Yes ❑ No Secondary Insurance ❑ Yes ❑ No	

Legal Name:			Relationship:
Preferred Name:			Language:
Date of Birth: / /		Social Security #: - -	
Assigned sex at birth: ❑ M ❑ F ❑ Choose not to disclose ❑ Unknown			
Preferred Pronouns: ❑ He/him ❑ She/her ❑ They/them			Office Use Only: ❑ RX ❑ MCR ❑ MCD ❑ DENT ❑ MED ❑ EC ❑ NONE ❑ HOLD ❑ SEC
Employer:	Is this person a seasonal farmworker? ❑ Yes ❑ No	Is this person a Veteran? ❑ Yes ❑ No	
Does this person have: Medical Insurance ❑ Yes ❑ No Dental Insurance ❑ Yes ❑ No Vision Insurance ❑ Yes ❑ No		Does this person have: Medicare ❑ Yes ❑ No Secondary Insurance ❑ Yes ❑ No	

Important Information about the Discount Program

1. Discount Program cards are not active until you see a provider and are good for 12 months from the approval, unless we tell you otherwise. We use the income ranges provided by the U.S. Government to calculate your discount. Even if your information does not change, you must complete a new application every 12 months. Sometimes you have to complete a new application before the end of 12 months. We will let you know if you have to. The list of things under "What you will need to apply" must be provided each time you apply for the program.
2. We only discount services offered by providers of Salina Family Healthcare Center. We cannot discount charges from a stay at the hospital, ambulance services, or doctors outside of Salina Family Healthcare Center.
3. We do not discount procedures that are not medically necessary. Medicare, Medicaid, and private insurance also do not pay for procedures that are not medically necessary. Examples of procedures that are not medically necessary include tattoo removal, piercing, cosmetic surgery, etc.
4. Please check with our billing office before your appointment if you have questions about if you get a discount on your procedure. Your provider will not know which services get a discount.
5. You must pay the full price for procedures that are not medically necessary.
6. If you do get discounted services, you will get notification in the mail along with a cost summary sheet.
7. If you do not get discounted services, you can still be a patient at Salina Family Healthcare Center, but will have to pay the full price of services provided.
8. **If the number of people who live in your house changes, you must tell us. If your income changes, you must tell us. You will have to reapply at that time. You may lose your discount if you do not.**
9. We have the right to check out any information you give us, either from a third party or directly from you.
10. We are required to contact the Office of the Attorney General about false information or misrepresentations, per federal requirements.
11. Salina Family Healthcare Center will bring court action for lying that breaks the law.
12. We might dismiss you for lying on your Discount Program application.
13. Payment is due at the time of service.
14. The Discount Program card is not an insurance card.

By signing below, I agree that I have read this page, and that everything I have provided on this application is true.

Signature: _____ Date: _____

Screener Signature: _____ Date: _____