CHRIST COMMUNITY HEALTH

For God so loved the world that he gave his one and only Son, that **whoever** believes in him shall not perish but have eternal life.

John 3:16

APPLICATION FOR FEE DISCOUNTS

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: _____ ACCOUNT NUMBER: _____

LIST SPOUSE AND DEPENDENT CHILDREN UNDER 18, AS CLAIMED ON TAXES, LIVING IN THE HOUSEHOLD AND THEIR DATES OF BIRTH

NAME	RELATION TO PATIENT	DATE OF BIRTH	GROSS MONTHLY INCOME
	SELF		

1. IF NO INCOME FROM A JOB, HOW ARE YOU SUPPORTED? _____
2. DO YOU HAVE HEALTH INSURANCE? ☐ NO ☐ YES
3. ARE YOU/ YOUR SPOUSE OFFERED HEALTH INSURANCE THROUGH AN EMPLOYER? ☐ NO ☐ YES
4. DO YOU HAVE MEDICAID IN GA OR SC, OR HAVE HAD MEDICAID IN ANOTHER STATE? ☐ NO ☐ YES
5. DOES ANYONE IN YOUR HOUSEHOLD HAVE A PENDING AUTO, WORKER'S COMP, OR OTHER PERSONAL INJURY CLAIM? ☐ NO ☐ YES
6. HAVE YOU/ YOUR SPOUSE LOST: JOB, INCOME, HEALTH INSURANCE, MOVED, MARRIED/DIVORCED IN THE LAST 60 DAYS? ☐ NO ☐ YES
7. DOES ANYONE IN YOUR HOUSEHOLD CURRENTLY NEED WIC? ☐ NO ☐ YES

You will need to provide verification of income for each household member- Mark ALL that apply

☐ EMPLOYMENT = **(4)** WEEKLY, (**2**) BIWEEKLY, (**1**) MONTHLY PAYSTUBS, LETTER FROM EMPLOYER WITH CONTACT INFORMATION

☐ UNEMPLOYMENT /WORKER'S COMP =BENEFIT LETTER
☐ SOCIAL SECURIT/ SSI = BENEFIT LETTER

☐ PENSION, DISABILITY, VA BENEFIT= BENEFIT LETTER

☐ ODD JOBS = SELF EMPLOYMENT DECLARATION FORM
SUPPORT FAM/FRIENDS- LETTER OF SUPPORT

☐ SELF EMPLOYMENT = COMPLETE TAX FORMS INCLUDING SCHEDULE C

☐ CHILD SUPPORT = INVOLUNTARY/VOLUNTARY = COURT ORDER OR LETTER FROM ABSENT PARENT

☐ ALIMONY = COURT ORDER OR LETTER FROM SPOUSE

☐ OTHER= PROOF OF ANY OTHER INCOME SUCH AS DIVIDENDS, INTEREST, RENTAL INCOME

☐ NO INCOME/ LIVING OFF OF SAVINGS = MOST RECENT BANK STATEMENT WITHIN 30 DAYS PRIOR TO APPLICATION

I have read and understand the "Fee Discounts Overview" and agree to follow its guidelines. I understand that I must provide the necessary proof of income documents to qualify for fee discounts. I will notify Christ Community Health Services as soon as possible if the size or income of my Household/Family changes. Based on the information shared in this application and the assessment made by CCHSA staff**, I agree to pay the discounted fee required of me for each visit.** I understand that the fee I have to pay may be different depending on the type of services I am receiving. I understand I may be required to pay additional fees for certain laboratory testing, supplies/equipment, or for dental services not considered "basic", and that these amounts will be discussed with me prior to receiving services. I affirm all information provided in this Application for Fee Discounts is true and accurate to the best of my knowledge. I give appropriate CCHSA staff permission to investigate any information provided in this application. I understand providing false information will result in no longer being eligible for fee discounts. **I also understand, once approved for the Fee Discount Program, I will receive a discount for dates of services to only include 30 days prior to the date of this application. I also understand that my eligibility will extend from the date of my signed application forward one year.**

_____ _____

SIGNATURE DATE

For Office Use Only:

ANNUAL INCOME: _____

HOUSEHOLD SIZE: _____

PROCESSED BY: _____ DATE: _____

COMMENTS: