Reduced Fee Application

Sadler Health Center Corporation is a nonprofit community health center. We receive money from many different sources so that we can provide medical and dental care to qualified individuals for a reduced fee based on family size and income. In order to determine if you qualify to receive a reduction to your bill, we need you to complete the following information and provide proof of your household income. You need to update this information annually or whenever your income or family situation changes, in addition to whenever requested by Sadler Health Center.

If your household income is greater than two times the amount defined by the Federal Poverty Guidelines, please initial here: _____________ If your income changes, please let us know at a future visit.

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD AND THEIR RELATIONSHIP TO YOU

Last Name, First Name Of all household members	Relationship	Insurance Yes/No		Monthly Income	Date of birth	Acct # Sadler Health Staff Use Only
	Self					
	Spouse					
	Child/Dependent					
	Child/Dependent					
	Child/Dependent					

*** Include Child/Dependents under 18 years of age. *list all household members on the back of application**

If you currently have insurance coverage, would there be a reason your coverage would be terminated within the next 30 days? (if so, please give anticipated termination date) ___________________________________

Household Address: ____ Apt: ___________________

City: __________________________________ State: ________________ Zip: ___________________

Phone: ____ Township: _________________________________

For today's visit you will receive a discount based on the information provided. In order to continue to receive this discount, you must provide proof of income. If income information is not provided, you will not be eligible for the discount. Please mail or bring one of the following proofs of income to Sadler Health Center Corporation before your next visit.

-Most recent pay stubs for each household member working (2)
-Proof of alimony or child support being received
-Worker's compensation payment determination
-Other sources of income not listed above
-Unemployment comp payment determination
-Social Security/disability determination letter
-Tax return or W2 (current)

Are you Self-Employed? Yes______ No______

By signing/submitting this application for participation in the reduced fee program, I understand that any and all information provided can and will be verified by Sadler Health Center. Furthermore, I understand that providing incomplete or false information could result in my dismissal from Sadler Health Center, as well as notification to other government agencies from which I receive benefits, including but not limited to: Pennsylvania Medical Assistance, Cumberland County Housing Authority, and Cumberland County Public Assistance Office.

I hereby certify that all information given on this application is correct and completed to the best of my knowledge. Permission is granted for Sadler Health Center Corporation to verify any information to determine my eligibility. I understand that otherwise, all information is confidential and will only be used in connection with enrollment in the Reduced Fee Program. **I UNDERSTAND THAT IF I DO NOT PROVIDE PROOF OF INCOME ALL FUTURE VISITS WILL NOT BE DISCOUNTED.**

Patient Signature ______________________________ **Date** ______________________________

***If you have any questions regarding the Reduced Fee Program, please contact the billing department at (717) 218-6670, and select option #4.**

Last Name, First Name Of all household members	**Please list other individuals living in your home and their relationship to you**	**Insurance**	**Monthly Income**	**Date of birth**	**Acct #** Sadler Health Staff Use Only

PLEASE DO NOT WRITE BELOW THIS LINE

FOR BILLING DEPARTMENT USE ONLY

REDUCED FEE APPROVAL

Income Amount: $______________________ **Weekly Bi-weekly Monthly Annually**
(circle one)

Family Size: ____________________ **Discount:** ____________________

Proof of Income Received and Verified: YES NO Date: ____________________

Effective From Date: ____________________ **Effective Through Date:** ____________________

Approval Date: ____________________

Patient Account Representative: ______________________________

Billing Manager: ______________________________ **Date:** ____________________