Application for Coverage Under Sliding Fee Discount Program (SFDP)

You must answer every question. If something does not apply to you put N/A in that space. You must sign and date the application before you send it in. If you do not sign the application your application will be denied.

Application is for (check one): Myself _____ or Myself and My family _____

Last Name:_____First name:_____

Street Address: _____
City:_____State:_____Zip Code:_____Phone: _____

Mailing Address (if different): _____
City:_____State:_____Zip Code: _____

List Members of Household

Name	Relationship to Applicant	Date of Birth	Gender	Employed? Yes or No	Primary Language

Is anyone in the household pregnant: _____Yes _____No

Does anyone in the household have medical insurance? _____Yes _____No

Whom: _____

Name of insurance _____ ID _____

Income Verification

Please list all sources of income for the household. Income to be included should include, but not be limited to, employment, unemployment compensation, disability, workers compensation, social security, supplemental security income (SSI), public assistance, veterans benefits, survivor benefits, pension or retirement income, interest, dividends, other investment income, rental income, royalties, income from estates and trusts, alimony, child support, and other income from outside the household and other miscellaneous sources.

Household Member's name	Income Source	Amount	Payment is weekly, biweekly, monthly, yearly

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You must include, with your application, either your last 4 weeks paystubs OR last year's tax return, AND any proof of the above benefits for your application to be processed.

I certify that the above information is true and complete. I authorize Lamprey Health Care to verify any of the above information and release the above information to referring/mutual providers of care. I understand that I am financially responsible for all bills for services prior to completion and acceptance of this application and if my application is denied. I understand that Lamprey Health Care is regulated by policies and regulations established by the federal government, and it is considered unlawful to misrepresent or falsely claim inaccurate information on this application.

_____ _____

(signature of applicant) *(date)*

FOR OFFICE USE ONLY:

Date application received: _____Name of employee receiving application: _____

- Weekly divide by 4.33
- Bi-Weekly divide by 2.17
- Semi-Monthly divide by 2

Assistance is granted at _____ % based on calculated annual income of $ _____ and family size of _____.

$_____was deducted from income due to child support payments (refer to policy, as to when this is allowable).

Assistance is denied due to:

_____ Income does not meet eligibility criteria
_____ Missing information, requested was not provided within 10 days
_____ Application was not signed

Notification to patient was mailed on _____
(date)
Signature of employee performing eligibility review: _____