



Healthcare is expensive and we can help!

Take advantage of our sliding fee discount program

- As a Federally Funded Community Health Center (FQHC) it is our policy to provide essential services regardless of the patient's ability to pay. Discounts and/or nominal fees are offered based on the household size and annual income.

To Apply for our sliding fee discount program

- Complete the application below and bring in proof of annual income to your upcoming appointment.
- Proof of income includes any of the following:
 - Your last current Federal Income Tax Return (with W-2) and if Self Employed, your current Business Tax Return with Schedule C. Other tax returns and schedules D or F if applicable
 - Your most recent pay stub prior to the date of the application. Preferably 2 consecutive pay stubs.
 - Unemployment or Worker's Compensation income is verified by the award letter or a copy of an actual check.
 - Disability can be verified by a copy of the check, award letter, or bank letter specifying the amount of direct deposit. Social Security can be verified by the awards letter showing gross income.
 - If pay stubs are not available, then a letter from the employer stating the income by noting hourly wage and hours worked per week including date, company name, address, telephone number and contact person.

Should you have any questions about our sliding fee discount program, please contact us at 843-663-8000 extension 9032.

PLEASE FILL OUT TO APPLY FOR ONE OF OUR PROGRAMS
FAMILY INCOME DOCUMENTATION WILL BE REQUIRED TO QUALIFY

| Family Income Members Legal Names | Relationship to Patient | Date of Birth | Age | Earned Gross Income (Year/Monthly/Biweekly/weekly) In Office Use ONLY |
|-----------------------------------|-------------------------------|---------------|-----|--|
| Patient Legal Name: | Self | | | |
| Other: | | | | |
| Other: | | | | |
| Other: | | | | |
| Other: | | | | |
| Other: | | | | |
| Total Number in Family: | A. Total Gross Income: | | | \$ |

| Sources of unearned Income | Yes | No | Proof | Amount (Weekly/Biweekly/Monthly/Year) | Total In Office Use Only |
|--|-----|----|-------|---------------------------------------|--------------------------|
| Alimony | | | | | |
| Child Support | | | | | |
| Supplemental Security Income (SSI) | | | | | |
| AFDC (Aid A2 Families with Dependent Children) | | | | | |
| Disability Benefits | | | | | |
| Pension | | | | | |
| Retirement | | | | | |
| Assistance (SNAP, Food Stamps etc.) | | | | | |
| Unemployment | | | | | |
| Second Part-Time Job | | | | | |
| Other Income | | | | | |
| B. Total Unearned Income | | | | | \$ |
| Total Annual Family Income from All Sources (A+B) | | | | | \$ |
| Tax Form Income | | | | | \$ |
| Individually Schedule Business | | | | | \$ |

I hereby certify that to the best of my knowledge that the above information I have provided on this form concerning income living arrangements to be true, accurate, and complete and that I have no income other than that listed above. I promise to notify Little River Medical Center, Inc. at once if there is a change to my income, mailing address or telephone number(s).

I will also notify the Little River Medical Center, Inc. front office if I obtain or have changes to my Medicaid, Medicare insurance or private insurance.

I release my eligibility and health information to pharmaceutical manufactures, or their designee, for the purpose of Institutional Patient Assistance Program (IPAP) audit if I receive eligible pharmaceutical products through one of the Little River Medical Center, Inc.'s pharmacy locations.

SELF PAY, CO-INSURANCE PERCENTAGE OR CO-PAY MUST BE PAID IN FULL AT TIME OF SERVICE

Applicant's Signature: _____ Date: _____

| | | |
|-----------------------------|---|----------------------------------|
| Interoffice Use Only: | _____ EIS – Early Intervention Services | _____ TFP – Teen Family Planning |
| # In Family: _____ | Total calculated annual family income: \$ _____ | |
| Approved SF: _____ | Effective dates approved from _____ | Expires _____ |
| Witness (LRMC Staff): _____ | Date: _____ | Patient Account Number: _____ |