



# Healthcare Discount Program Application *(internet)*

Upon approval; discount will be applied to the services rendered at any of the following clinics:

**Please place and "X" beside the clinic(s) in which you are a patient**

\_\_\_\_\_ Dexter    \_\_\_\_\_ Dover    \_\_\_\_\_ Newport    \_\_\_\_\_ Canaan    \_\_\_\_\_ Pittsfield

Date of Application: \_\_\_\_\_ New Patient: (circle one) Yes / No

Patient Name:	Birth Date:	Age:
Guardian Name (if patient is under 18 years old):		
Address:		
City, State, Zip:		
Phone	Cell Phone	

It is the policy of Sebasticook Family Doctors to provide health care services to its patients at a cost that is affordable to its patients. Health Center must know and document how much money patients have in order to provide health care services at an appropriate fee based on Health Center's Sliding Fee Scale / Nominal Fee. This information may also help Health Center to help patients with other programs that offer financial assistance or benefits to patients. If you have any questions about this form, please ask Beth Page, Outreach Coordinator (355-3049). Thank you.

**How did you hear about our Healthcare Discount Program?** \_\_\_\_\_

**Number Living in Household**

Name:	Relationship:	DOB:
Name:	Relationship:	DOB:
Name:	Relationship:	DOB:
Name:	Relationship:	DOB:
Name:	Relationship:	DOB:

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 List all **HOUSEHOLD** income and **ATTACH PROOF OF INCOME**

Income Type/Document	Income Amount	Copies Provided
One-Month's Worth of Pay Stubs		
Employer Report Letter – Income Statement		
TANF Letter		
1040 Tax Form with all corresponding W-2 for most recent calendar year		
Self Employed Wage Documentation		
Statement of Social Security Benefits (SSI, SSDI, SSRI)		

Income Type/Document	Income Amount	Copies Provided
Military Leave and Earnings Statement		
Foster Care statement from Social Services		
Current statement of Alimony		
Unemployment benefits		
Workers compensation benefits		
Local cash assistance benefits		
Pension of Annuities		
Cash amounts received or withdrawn from any source including savings, investments, trust accounts, or other resources readily available		
Patient Report Letter – Income Statement, signed and witnessed by a staff member		
Other: _____		

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I request that Sebasticook Family Doctors (SFD) make a determination of my eligibility for the sliding scale for medical services rendered by any SFD medical facility. I understand that the information that I submit is subject to verification by SFD. I also understand that if the information, which I submit is determined to be false, such a determination will result in denial of the sliding scale eligibility, and I will be liable for payment in full. If at any time my income changes it is my responsibility to inform Sebasticook Family Doctors of those changes. Failure to comply may affect my sliding scale eligibility.

I affirm that the above and attached information is true and correct to the best of my knowledge. If I become eligible for the sliding scale and do not make the required payments, I am aware that my account, and/or the accounts of my eligible family members listed above, can be sent to a collection agency.

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_