Quincy Medical Group

Rural Health Sliding Fee Scale Application

Site: ______________________________

(217) 222-6550, Ext. 3444

To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income every year.

Section A

Head of Household	Place of Employment		
Home Address:	State	Zip	Home Phone
Mailing Address:	State	Zip	Mobile Phone
Do you have insurance: Y/N List name of insurance:			

Section B

	First and Last Name	Date of Birth
Self		
Spouse		
Dependent		
Dependent		
Dependent		
Dependent		
Dependent		

Section C

Monthly Household Income

Source	Self	Spouse	Tax Dependent	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Unemployment, worker compensation, strike benefits				
Interest; dividends; royalties; income from rental properties, estates, and trusts; assistance from outside the household; and other miscellaneous sources				
TOTAL INCOME				

Section D -Verification of income is required

Verification Checklist (attach copies)	**Yes**	**No**
Identification/Address: Driver's license, employment ID, utility bill or other ID		
Income: Prior year tax return and four most recent pay stubs		
Insurance: Insurance card(s) if applicable		

If tax return or pay stubs are not attached, you must document why
If a tax return was not filed, you **must** have note from IRS with reason*

To be assessed the Sliding Fee Discount Program applicants must provide the Business Office with requested information as indicated on the application.

Authorization

I certify that the above information is true to the best of my knowledge and understand that verification is required for approval. I agree to inform the provider of services, within 10 days, if there are any changes in my income, persons in the household or of any change of addresses. I understand that if I do not qualify for the sliding fee scale, I will be personally liable for the charges for services rendered. I hereby authorize Quincy Medical Group to investigate any references, statement or other data provided by me pertaining to my credit and financial responsibility.

I also understand that if I am approved for the Sliding Fee Discount Program, that my Sliding Fee payment is due at the time of service. However, payment arrangements are available if I am unable to pay the entire fee.

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Guarantor Signature Date

Pay class approved ___________	Effective Date ___________	Recertification Date ___________
Processed by ___________ Date ___________	Approved by _______________	Date ___________
Guarantor Notified (Date) ___________	Recertified by ___________	Guarantor Notified (Date) ___________