

#### SLIDING FEE SCALE PROGRAM RULES OF PARTICIPATION

The following items are required to process your application for La Maestra Sliding Fee Scale Program. Your application will NOT be processed without the requested information. Any information given to La Maestra, will be kept confidential. If the information proves FRAUDULENT we reserve the right to cancel your Sliding Fee Scale status and bill you in full for all previous visits.

### Information needed for your Sliding Fee Application is as follows:

- 1. A total number of household members
- 2. Proof of the household income. All incomes by any household member must be reported

Employment Wages Social Security Pensions

Child Support Alimony Unemployment, etc.

We require one (1) current check stub for every household member in the household holding employment. Current meaning not more than 60 days old. If check stubs are not available you must provide a current tax form or statement from the employer on their business letterhead of your gross income or one (1) month's worth of household bank statements including but not limited to checking or savings account.

3. If you have no income you may also provide proof of applying for Medicaid benefits or a copy of Food Stamp Certification.

Before you sign up on the Sliding Fee Scale Program please read the following rules.

### THESE RULES MUST BE FOLLOWED WITHOUT EXCEPTION:

- 1. LA MAESTRA FAMILY CLINIC, INC. MUST BE NOTIFIED IMMEDIATELY IF:
  - a) There is a change of income of any family member in the household
  - b) Any member of the household obtains insurance of any kind
  - c) There is a change in the number of family members within the household.
  - d) There is a change in mailing address.
- 2. YOU MUST PAY YOUR CALCULATED FEE AT THE TIME OF EACH VISIT.

Your calculated fee is expected at the time of service, in the event that you are not able to pay you will be asked to sign a promissory note and LMFC will send you a bill. Visits that are more complex than originally expected may result in higher a cost. In these instances the balance will be the responsibility of the patient.

I,understand that if I do not comply with	, have read the above rules and agree to follow them. In the rules set forth, my participation in the program will be terminated.	I also
Applicant's Signature	Date	
Signature of LMFC Staff	Date	



# LA MAESTRA SLIDING FEE SCALE PROGRAM APPLICATION HOUSEHOLD DATA

Name:							
Last			First		N	ΜI	
Social Security Nu	ımber:						
Current Address:_							
	No.	Street	Name	Cit	ty	CA	Zip Code
Home Phone#: (	)			Worl	k Phone #:	( )	<del></del>
Permanent Addres	ss:						
		No. S	treet Name		City	CA	A Zip C
Are you or any otl	ner hous	sehold n	nember cov	ered by health in	surance, N	Medical or Medi	care? Yes / No
Please list any oth	er mem	bers livi	ing in the al	ove household:			
Name		Date	e of Birth	Relationship	Sex	Social Secur	rity
ease list all house	ehold m	iembers					_
erson Employed			Company Name/Occupation			Monthly Gross Income	
ub Total						2	

### Please list all other sources of income received by any household member:

Other Income/Benefit	Amount
Social Security Benefit	
S.S.I.	
Child Support	
Retirement Pension	
S.S.D.I.	

Unemployment	
Alimony	
Other (specify)	
Grand Total of All Income Received	\$

Please read carefully before signing:

Verification of income is mandatory. By signing below, I agree that La Maestra Family Clinic (LMFC) may contact each employer of all persons working in the above mentioned household and/or any contact various agencies to verify any source of income. I will provide LMFC a copy of current proof of income. I understand that services will be discounted only after all requested information is provided.

I verify that all information provided on this form is true and correct. A false answer to any portion of the application may jeopardize your status at LMFC and/or punishable by law.

So that LMFC may maintain an updated Sliding Fee Scale Application of file, you will be asked to reapply for the Sliding Fee Scale program on a yearly basis.

Signature Verified and Obtained Information by:	Date
Signature of LMFC Staff	Date
Qualified Poverty Percentage:	

Medical	Dental	Behavioral	Optometry	Chiropractic	Acupuncture	Pharmacy	Slide	Slide
Slide	Slide	Health	Slide	Slide	Slide	Slide	Effective	Termination
Category	Category	Slide	Category	Category	Category	Category	Date	Date
		Category						



## Household Size and Income – Self-Declaration

### SLIDING FEE ELIGIBILITY

We appreciate the opportunity to provide you with health services. It is necessary for us to ask personal questions in order to determine if you qualify for a sliding fee discount on the health services rendered. This information is strictly confidential and cannot be released without your permission. In order to qualify for the sliding fee scale, you will need to declare your income annually or whenever there is a change.

Please	select one of the following:				
	I have provided proof of income and declare the number of people so	upported including myself is			
	I declare that I do not have documentation of my tax returns, pay stu My family's monthly income is \$ / ( ) yr. ( ) mo. ( ) verified the number of people supported including myself is				
	I declare that I have no source of income and I am receiving room armyself is	nd board and family size including			
	I refuse to provide financial information and understand that I will be	charged full pay for services.			
	PATIENTS AFFIRMATION OF INFO	PRMATION			
I affirm that the information I have provided to La Maestra Community Health Centers is accurate and true to the best of my knowledge. I understand the following:					
	If I have willfully falsified information, I may be disqualified from the s If this information changes, I must re-apply with current information. It is my responsibility to re-determine my eligibility before the expiration				
Patient'	s Signature	Date			
Relation	nship to Patient				