Oak Orchard Health Sliding Fee Application

☐ Albion ☐ Hornell Dental ☐ Optical
☐ Brockport ☐ Lyndonville ☐ MDU
☐ Hornell ☐ Warsaw ☐ Field

Date Stamp

_____
Initial

Because we are a Community Health Center, we may be able to offer a discount on your services based on your household income and family size. Complete this Sliding Fee application and provide verification of income to allow us to determine if you are eligible.

Head of Household Information:

Name: (First, middle initial, Last):	Home Phone:	Cell Phone:	Work Phone:
Address:	City:	State & Zip:	County:
Email Address:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner/significant other		

Household Information: List ALL individuals supported in the household, including the head of household.

Name	Date of Birth (Age, if unknown)	Relationship	OOH Patient	Employed	Name	Date of Birth (Age, if unknown)	Relationship	OOH Patient	Employed
		SELF	Yes/No	Yes/No				Yes/No	Yes/No
			Yes/No	Yes/No				Yes/No	Yes/No
			Yes/No	Yes/No				Yes/No	Yes/No
			Yes/No	Yes/No				Yes/No	Yes/No
			Yes/No	Yes/No				Yes/No	Yes/No
			Yes/No	Yes/No				Yes/No	Yes/No

Income Information: Please complete for all adult household members who are employed. Proof of income (see attached) must be provided to Oak Orchard Health (OOH) with this application.

				How often is employed person paid? (check one)				
Employed Person	Employer Name	Total Weeks Worked Annually	Income (Before Taxes)	Weekly	Every 2 Weeks	Monthly	Annually	Office Use Only
			$					
			$					
			$					
			$					

Other Household Sources of Income:

		How often is this source paid? (check one)				
Other Sources	Income (Gross)	Weekly	Every 2 Weeks	Monthly	Annually	Office Use Only
Alimony	$					
Child Support	$					
Social Security	$					
Social Security	$					
Pension / Retirement	$					
Pension / Retirement	$					
SSI	$					
Disability	$					
Unemployment	$					
TANF / Other:	$					
Other:	$					

By signing below, I agree that the OOH staff may contact each employer listed and/or other agencies to confirm my income. I will provide OOH with proof of income for the purpose of calculating my discount. I will be asked to reapply for the program on an annual basis. I agree to inform OOH if there are changes to my household income, household size or insurance coverage. I understand that certain services and/or items cannot be discounted. I understand that coverage is subject to change at any time. I agree to pay my copay at the time of services. I hereby certify that the information I provide is correct.

Applicant Signature: _____ Date: _____

Guardian or Power of Attorney Signature: _____ Date: _____

FOR OFFICE USE ONLY:	Total Income:	Expire Date:	Co-Pay:	Pharm/Lab/X-Ray %:

Oak Orchard Health (OOH) - Sliding Fee Discount Program Requirements

In order to receive reductions in fees through the Sliding Fee Discount Program, **applications must be completely filled out, documentation attached, signed and dated within 30 days from the date at the top right corner of the application**. **If you are approved for the program, OOH will discount services back to the date at the top of the application. If we receive the application after 30 days, you will be eligible for future discounts if you qualify.** You will receive a letter informing you of the status of your application.

Household Information: List all family members living in your household and the required information on the form. Often these are the same individuals claimed as dependents when filing your tax return.

Income Information: List all household income, both taxable and non-taxable for you, spouse/partner/significant other and dependents. This income includes but is not limited to, Wages and Tips if applicable, Pensions, Annuities, Veteran Benefits, Social Security Benefits (net amount after deductions for Medicare), Alimony, Child Support, Workers Compensation, State Unemployment Insurance, Self-Employment Income, Rental Income, Farm Income and Small Business Corporation Income. Be sure to indicate the frequency of the income amount on the form. If you are a seasonal worker, indicate the number of weeks you work during the year.

Attach the following proof of income documentation to the application:

One (1) month of current recent pay stubs showing gross wages, **OR** a signed letter from your employer stating your current month's gross salary, **OR** a copy of page 1 and 2 of your most recent federal tax return filed (IRS Form 1040).

If you file **any** of the Schedules below with your tax return, we will need a copy of these schedules:

- Schedule C - Profit or Loss from Business
- Schedule F - Profit or Loss from Farming
- Schedule E - Supplemental Income and Loss (often relates to rental income)
- Schedule K-1 – relating to Income from Partnerships and Corporations

AND, if you receive:

Social Security Benefits and/or Pension Benefits - copy of the statement you receive at the beginning of the year stating what your monthly benefits will be. If you get your benefits directly deposited to your account, we will need a copy of the bank statement showing such deposits.

Alimony and child support payments - copy of the court document or a letter from who you are receiving these payments stating the amount paid and how often the payments are made and who the payments are for.

Unemployment insurance – copy of document stating what your benefits are, weekly rate, when they began.

If you have **no** income at all, we need a signed statement from you stating how you are being supported.

If any of your Income or Household information changes in the next 12 months, you are responsible for informing us. You will need to apply for this discount every 12 months.

If you have any questions, please call Ron Weiss at (585)-637-3905 ext. 324. **Please send completed applications with attached documentation to: Oak Orchard Health, Attention: Sliding Fee Dept., 300 West Avenue, Brockport, NY 14420** or return to the Front Desk**.**