



***** FOR OFFICE STAFF ONLY *****

<input type="checkbox"/> RQ	<input type="checkbox"/> NBRP	<input type="checkbox"/> FCHS
<input type="checkbox"/> AFM	<input type="checkbox"/> NBRD	<input type="checkbox"/> SWOC
<input type="checkbox"/> SWFM	<input type="checkbox"/> HHC	<input type="checkbox"/> OOC

MRN _____ SFS Patient Type _____

Part I: REGISTRATION

Please complete to the best of your knowledge. For areas that do not apply to the patient please enter "N/A".

Patient's Name <i>First MI Last</i>			Date of Birth (DOB) <i>MM/DD/YY</i> <input type="checkbox"/> Under 18?		
Mailing Address <i>Street</i>		<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>
Physical Address <i>Street</i> <input type="checkbox"/> Same as Mailing		<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>
Social Security # / Tax ID	Race/Ethnicity (check all that apply) <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CONTACT INFORMATION

1st Phone ____ - ____ - _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	2nd Phone ____ - ____ - _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	3rd Phone ____ - ____ - _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Emergency Contact: <i>Name</i>	<i>Relationship</i>	<i>Phone</i> ____ - ____ - _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
How did you hear about us? <input type="checkbox"/> Family/ Friend <input type="checkbox"/> Shelter <input type="checkbox"/> Health Dept. <input type="checkbox"/> Hospital <input type="checkbox"/> Media <input type="checkbox"/> Social Services <input type="checkbox"/> Other _____		
Guarantor's Name <i>First MI Last</i> <input type="checkbox"/> Same as Patient (Parent or guardian if applicable)		DOB <i>MM/DD/YY</i>
Social Security # / Tax ID	Relationship	Phone ____ - ____ - _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Does the patient have Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No if no, please skip to part II.	Primary Insurance Carrier	Secondary Insurance Carrier

Have you been seen by a health provider in the last 12 months, including the ER, Hospital, Health Department, Urgent Care, or doctor's office?
 Yes No If YES where/when? _____

IF PATIENT IS A CHILD OR MINOR PLEASE COMPLETE BELOW:

Parent's/Guardian's Complete Name: First: _____ MI: _____ Last: _____
 Address: _____ City: _____ State: _____ Zip code: _____
 Home phone # _____ Employer: _____ Work phone # _____

Child lives with: _____ Nearest relative not in the home: _____ Day Phone # _____

Release and Authorization/ Signature on File Statement

I hereby request, authorize and consent to medical care, including diagnostic procedures, HIV testing, and medical treatments as appropriate related to the health problem(s) for which I have sought services from Wake Health Services, Inc. (Wake Health). I authorize Wake Health to release information about me to my insurance company/companies, Medicare or Medicaid as appropriate. I request payment of medical insurance benefits related to these visits be paid directly to Wake Health. I understand that I am responsible for payment in full for any of my bills or services not paid by insurance.

Patient/Guarantor/Guardian Print

Patient/Guarantor/Guardian Signature

____/____/____
Date

Part II: SLIDING FEE SCALE ELIGIBILITY QUESTIONNAIRE

- 1- Are you claimed as a dependent on a relative's taxes? Yes No
- 2- Have you applied for Medicaid or had Medicaid coverage in the past year? Yes No

Adults without Children under 18 - Answer Below

- 3- Are you a US Citizen, refugee or lawful permanent resident admitted at least five years ago?
 Yes- Go to question 4 No- Go to Part III
- 4- Are you age 65 or older?
 Yes- Apply for Medicare No- Go to question 5
- 5- Are you receiving Social Security Disability? Have you been or will you be disabled for 12 months? Are you legally blind?
 Yes-Apply for Medicaid No- Go to Part III

Adults with Children under 18 - Answer Below

- 3- Are you under age 19, pregnant, OR the primary caretaker of a child living your home is under the age of 19?
 Yes- Go to question 4 No- Go to Part III
- 4- Are you a US citizen, refugee, or lawful permanent resident admitted at least 5 years ago?
 Yes- Apply for Medicaid No- Go to Part III

Part III: SLIDING FEE APPLICATION

Please complete the form, answer ALL questions and submit ALL applicable documents from the check list below. When complete, please sign the bottom of the page. Incomplete applications (including lack of documents) will not be processed.

Required Supporting Documents for Sliding Fee Scale Application (Please Check All That Apply)		
<input type="checkbox"/> Photo I.D for patient and ALL adults claimed as dependents <input type="checkbox"/> Proof of Homeless Status (If Homeless ONLY) <input type="checkbox"/> Birth certificate, social security card, insurance card, or School I.D. for all dependents claimed under 18 <input type="checkbox"/> Pay check stubs showing GROSS amount for past 30 days for patient and all working claimed dependants, or letter from employer <input type="checkbox"/> Current tax returns if (1) self employed (2) claiming an adult as a dependent (3) applying for drug assistance or (4) receive dividends or profit from stock	<input type="checkbox"/> Proof of Unemployment For letter, call Employment Securities Commission 1-888-737-0259. <input type="checkbox"/> Social Security Income - early retirement, retirement, or disability. For letter, call Social Security Admin - 1-800-772-1213. <input type="checkbox"/> Proof of pension <input type="checkbox"/> Proof of child support and/or alimony For letter, call court where ordered <input type="checkbox"/> Proof of county residence	
HOUSEHOLD		
<i>Please list family members who live in your household and are claimed as dependants for tax purposes:</i>		Total Household Size: _____
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN

***** If you will be applying for the Drug Assistance Program (DAP) you will be asked to provide your most recent tax forms to the pharmaceutical companies to qualify for the program*****

I HEREBY CERTIFY THAT I LIVE IN THE STATE OF NORTH CAROLINA, AND THE INFORMATION SUBMITTED IS TRUE TO THE BEST OF MY KNOWLEDGE. I also give permission to Wake Health Services, Inc to contact any individual that may have information regarding my eligibility. I declare, under penalty of perjury, that the information on this form, my Federal Income Tax Return, and my accompanying schedules submitted with this application to Wake Health Services are true, correct and complete. If it is determined that any of the information provided is not accurate or I fail to immediately notify Wake Health Service of any changes, I understand that I will be removed from the SFS program and all charges will be reinstated. I also agree to pay the determined co-pay at the time of my medical or dental visits. I understand that failure to pay the co-pay at the time of service will result in my removal from the SFS program.

_____ /_____/_____
 Patient/Guarantor/Guardian Print Patient/Guarantor/Guardian Signature Date

SFS Supporting Documentation – for staff use

I. FOLLOW UP QUESTIONS

<p>1. Is patient married, divorced, or widowed?</p> <p>a. Married: spouse must be listed on application and documentation of their income is required.</p> <p>b. Divorced: Proof of alimony required</p> <p>c. Widowed: Proof of widow's pension required</p> <p>2. Is the person applying for the discount program a full time student and claimed as a dependent on their parent's taxes?</p> <p>a. If yes, ask: do parent's provide insurance for them? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. If yes, they cannot get SFS.</p> <p>c. If no, the patient's parent's will need to be included on the SFS application & all income documentation would be required.</p> <p>3. Has the patient applied for Medicaid?</p> <p>a. If yes, notify them that they must tell MCD about their self pay visit to get reimbursed retroactively. Medicaid Pending Financial Class, Self Pay Insurance Carrier</p> <p>b. If patient has been eligible for Medicaid in the past year, treat as Medicaid Pending until confirmation of ineligibility is received from Department of Human Services</p>	<p>4. Is the patient a veteran?</p> <p>a. If yes, ask: where you dishonorably discharged? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. If yes: eligible for SFS. If no: eligible for veteran's benefits and not SFS.</p> <p>5. Does patient and/or spouse have zero income?</p> <p>a. If yes, ask where they are living and how they are supporting themselves _____</p> <p>b. If yes, income must be verified by Wake County Dept. of Human Services</p> <p>6. Does patient have child/children?</p> <p>I. If yes, do the child/children have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>a. If yes and the insurance is Medicaid, has the parent(s) applied for Medicaid also?</p> <p>b. If yes, we need documentation of denial;</p> <p>c. If no, inform the parent(s) that depending on their income and household size they may have to go apply</p> <p>II. Do children receive child support, disability, other income? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. If yes, we need documentation</p>
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II. INCOME WORKSHEET

Sources of Income for all Members Living in Household Claimed as a Dependant:			
Check Stubs (30 days)	\$ _____ wk/bi-wkly/mo _____ yr	Social Security Income	\$ _____ mo _____ yr
Letter from Employer	\$ _____ wk/bi-wkly/mo _____ yr	Pension	\$ _____ mo _____ yr
Current Tax Returns	\$ _____ yr	Child Support Award Letter	\$ _____ mo _____ yr
Unemployment Letter	\$ _____ wk _____ yr	Alimony Award Letter	\$ _____ mo _____ yr
Workmen's Compensation	\$ _____ mo _____ yr	Dividends/Interest	\$ _____ mo _____ yr
Disability Benefits	\$ _____ mo _____ yr	Other Income (e.g. one-time pmt)	\$ _____ mo _____ yr
Income from Property	\$ _____ mo _____ yr		
Total Annual Household Income: _____			
Required Supporting Documents for Sliding Fee Scale Application			
<input type="checkbox"/> Photo I.D for patient and ALL adults claimed as dependents <input type="checkbox"/> Proof of Homeless Status (If Homeless ONLY) <input type="checkbox"/> Birth certificate, social security card, insurance card, or School I.D. for all dependents claimed under 18 <input type="checkbox"/> Pay check stubs showing GROSS amount for past 30 days for patient and all working claimed dependants, or letter from employer <input type="checkbox"/> Current tax returns if (1) self employed (2) claiming an adult as a dependent (3) applying for drug assistance or (4) receive dividends or profit from stock	<input type="checkbox"/> Proof of Unemployment For letter, call Employment Securities Commission 1-888-737-0259. <input type="checkbox"/> Social Security Income - early retirement, retirement, or disability. For letter, call Social Security Admin - 1-800-772-1213. <input type="checkbox"/> Proof of pension <input type="checkbox"/> Proof of child support and/or alimony For letter, call court where ordered <input type="checkbox"/> Proof of county residence		
_____ Staff Member Completing Application Print	_____ Staff Member Completing Application Signature	____/____/____ Date	
_____ Manager Print	_____ Manager Signature	____/____/____ Date	

III. INCOME CALCULATIONS

Income Payments	Check Amounts	Example	Sample Calculation	Annual Income
Monthly		\$700 on 1st, (e.g. disability check)	Multiply by 12	\$700 x 12 = \$8,400 annual
Bi-Monthly	Same	\$350 on 15th, \$350 on 30th	Multiply by 24	\$350 x 24 = \$8,400 annual
Bi-Monthly	Different	\$200 on 15th, \$150 on 30th	Add together, multiply by 12	\$350 x 12 = \$4,200 annual
Weekly	Same	\$100 x 4 weeks	Multiply by 52	\$100 x 52 = \$5,200 annual
Weekly	Different	\$100, \$50, \$150, \$100	1) Add all 4 amounts 2) Divide by 4 for average 3) Multiply by 52	\$100 + \$50 + \$150 + \$100 = \$400 \$400 / 4 = \$100 per week \$100 x 52 = \$5,200 annual
Bi-Weekly	Same	\$200 every 2 weeks	Multiply by 26	\$200 x 26 = \$5,200 annual
Bi-Weekly	Different	\$100, \$300	1) Add both amounts 2) Divide by 2 for average 3) Multiply by 26	\$100+\$300 = \$400 \$400 / 2 = \$200 per bi-week \$200 x 26 = \$5,200 annual