***PLEASE FILL OUT ALL SECTIONS***

# *WellOne Primary Medical and Dental Care*

## *Application to Receive Reduced Fee Medical and Dental Services*

***Patient's Information:***

| *Name* | *DOB* | *SS#* |
|---|---|---|
| _____ | _____ | _____ |

***Phone Numbers*** ***Address***

***Home Phone:***_____ _____

***Cell Phone:***_____ _____

***Please List all people living in the household*** ***(excluding patient above)***

| *Name* | *DOB* | *Relationship* | *SS#* | *Included in this Reduced Fee Application (Yes or No)* |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

| | | | |
|---|---|---|---|
| ***Are you currently employed?*** | ***Yes*** _____ | ***No***_____ | |
| ***Do you collect unemployment?*** | ***Yes*** _____ | ***No***_____ | |
| ***Do you collect Disability Insurance?*** | ***Yes*** _____ | ***No***_____ | |
| ***Do you collect SSI?*** | ***Yes*** _____ | ***No***_____ | |
| ***Do you have IRA's, Pensions etc?*** | ***Yes*** _____ | ***No***_____ | |
| ***Do you have Medical Insurance*** | ***If yes, Insurance Name***_____ | ***No***_____ | |
| ***Do you have Dental Insurance*** | ***If yes, Insurance Name***_____ | ***No***_____ | |

***(CONTINUED ON OTHER SIDE)***

***Office Use Only***

***Wage:***_____

***# Dependents:***_____

***Level A B C D F***

***Original RF Date:***_____

***Date Letter Sent:***_____

***Service: M D BH***

***Location: P F NK***

***Approved by:***

# *WellOne Primary Medical and Dental Care*

## *Application to Receive Reduced Fee Medical and/or Dental Services*

***Terms and Conditions***

1. A reduced fee schedule (also referred to as sliding fee scale) is available to qualifying patients of WellOne Primary Medical and Dental Care.
2. Fees for most services may be reduced to a nominal level as defined by WellOne Primary Medical and Dental Care's Board of Directors
3. Both uninsured and insured patients shall be eligible for reduced fees.
4. Uninsured patients who satisfy eligibility criteria shall be required to apply for health insurance coverage through Medical Assistance (including the State's Rite Care Program) or other state programs including the Women's Cancer Screening Program.
    a. Eligible patients shall be referred to an Agency's Official for enrollment into the applicable state program.
    b. Eligible patients who refuse to enroll into the applicable state program shall not be eligible for reduced fee services at WellOne.
5. Co-pays, coinsurance and deductibles of insured patients are eligible for reduced fee discounts under this program.
6. Patients must complete the application and submit all financial documentation requested to become eligible for reduced fee services. A new application must be completed every twelve months.
7. Patients who refuse to comply with the application and verification of income process shall not be eligible for reduced fee services at WellOne.
8. Payments for services ( including nominal fees) must be made at the same time services are rendered. Patients who do not comply with this policy may become ineligible for services at WellOne Primary Medical and Dental Care.

I, _____ am applying for reduced fee services at WellOne Primary Medical and Dental Care. I have reviewed and understand the above terms and conditions and agree to comply with them. I certify that I have fully disclosed my health insurance policy information and that I am not eligible for coverage through Medicaid or other state programs. The information contained in the accompanying application is accurate and complete to the best of my knowledge and belief. I agree to notify WellOne should my insurance, income or family situation change in a manner that may affect my eligibility for reduced fee services. I understand that intentional falsification of information provided herein or the omission thereof constitutes fraud and may be punishable as a crime in accordance with applicable laws and regulations.

_____

**Patient's Signature** **Date**

## List of Documentation Needed

1. **Application Completely Filled Out.**
2. **Copy of Most Recent Federal Income Tax Return (No W-2's)**
3. **Copy of Documentation including SSI, SSDI, Workers Compensation, Pensions, Garnished Wages, most recent Paystub.**
4. **If you are not working or collecting any income, you must supply a written letter from individual(s) supporting the patient.**
5. **Included with letter (item 4), a Notarized Applicant's Affidavit, which can be provided at WellOne.**