PLEASE FILL OUT ALL SECTIONS

WellOne Primary Medical and Dental Care

Application to Receive Reduced Fee Medical and Dental Services (Long-Form)

Applicant's Information:

Name	*DOB*	*SS#*
_____	_____	_____

Phone Numbers	*Address*
*Home Phone:*_____	_____
*Cell Phone:*_____	_____

Please List all Family Members; ***excluding patient above (see back of form for guidance)***

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
*Income:*_____
*# 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.
5. Family is defined as a group of two or more people (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Family is also defined as any form of non-married spousal couplings, with or without dependent children.
6. Co-pays, coinsurance, and deductibles of insured patients are eligible for reduced fee discounts under this program.
7. Patients must complete the application and submit all financial documentation requested to become eligible for reduced fee services. A new long-form application must be completed every two years. A short-form reduced fee application should be completed for interim years.
8. Patients who refuse to comply with the application and verification of income process may not be eligible for reduced fee services at WellOne.
9. Payments for services (including nominal fees) are required at the 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, including whether or not I am 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 eligiblity 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.

_____

Applicant's Signature **Date**

List of Documentation Needed with application

1. **Completed Application.**
2. **Copy of Most Recent Federal Income Tax Return (no W-2's please).**
3. **Copy of Income 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), an Applicant's Affidavit, which can be obtained at WellOne.**