Lewis County Primary Care Center Doing Business As...

PrimaryPlus

INCOME-BASED PAYMENT PROGRAM (Sliding Fee)

Please list all persons (including yourself) in your home:

Name	Social Security	Birthdate
	- -	/ /
	- -	/ /
	- -	/ /
	- -	/ /

Any additional family members & information may be put on another sheet & attached

Address: **Telephone Number:**

Is any person in your household employed? YES or NO
If YES, Who is employed? _____
Employer's name: _____

Salary? $_____ per wk/mo/yr. (Documentation Required).
Do you have insurance through your employer? YES or NO
If YES, Insurance: _____ Policy # _____

Does a household member receive any of the following benefits?: SSI, Social Security, Child Support, Alimony, Worker's Comp., Unemployment, Pension, Annuity, Other: _____?

Amount Received? $_____ per wk/mo/yr.

N O T I C E - REDUCED CHARGES ARE TO BE PAID AT THE TIME OF THE OFFICE VISIT.

The above information is true and correct to the best of my knowledge. I grant the Lewis County Primary Care Center, Inc. permission to verify the above information from all available sources. I agree to notify the Lewis County Primary Care Center, Inc. if there are any changes in my financial situation.

Signed _____ Date _____

FOR OFFICE USE ONLY

Interviewer _____ Executive Director _____
Amount of Discount approved _____% Patient Pays _____%
Acct # _____ Income _____ Card _____ File noted ____ Adj Made ____

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Lewis County Primary Care Center doing business as PrimaryPlus offers a payment program based on your household income and number of family members.

The reverse is a **SLIDING FEE APPLICATION.** *****Please complete and return with proof of **ALL** household income. **FAILURE TO PROVIDE PROOF OF ALL INCOME WILL DELAY PROCESSING.** *****

Acceptable forms of income include:

- Recent paystubs
- Unemployment statements
- SSI/SSA award letters
- Tax returns
- Pension or Workers' Compensation documentation

If you have no income or work odd jobs, please supply the following:

- Denial letter from Dept. of Health & Human Services
- Denial letter from K-Chip
- Denial letter from Medicaid
- Letter for Food Stamps (all pages).

Please bring this documentation to our front desk clerk and we will be happy to make copies – we do not wish to keep originals on file.

If qualified, you are eligible for a discount ranging from **25% to 75% on all Medical Services** and a discount ranging from **25% to 50% on all Dental Services** offered at the center (co-pays, all injectable medications, medical equipment, etc. **are NOT ELIGIBLE** for discount.)

However, once approved, to remain eligible **YOU MUST MAKE EVERY EFFORT TO PAY YOUR PORTION ON THE DAY THAT SERVICES ARE PROVIDED.** Please be prepared to make a payment at the time of checkout. Failure to comply with this requirement will make your application **VOID**, therefore making you ineligible for further discount.

Sliding fee applications **must be updated on an annual basis**, or sooner, if your household income changes.

Please feel free to call our Patient Services Department should you have any questions concerning your application.
PLEASE RETURN COMPLETED APPLICATION TO ANY PRIMARYPLUS LOCATION OR MAIL TO:

PrimaryPlus Sliding Fee Scale
P.O. Box 550
Vanceburg, KY 41179

I have read the above and I understand its content and significance.

Signed _____ **Date** _____

THANK YOU

(APPLICATION ON THE REVERSE SIDE)