**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Kintegra Health is dedicated to providing quality health care including health education and preventative care services to all members of the community regardless of financial barriers (ability to pay) through regular publication of a sliding fee scale.

Underinsured/Uninsured patients of Kintegra Health, Inc. with a household income at or below 200% of the Federal poverty level (FPL) and that provide required documentation will be eligible for medical, dental, and prescription discounts. Kintegra Health will annually revise and re-issue its sliding scale to reflect changes in the Federal Poverty guidelines.

By completing this this document, I agree that:

* All of the information provided on this application is true and correct and the applicant has not omitted any material matters in providing the information.
* At any time there is a change in the total family income or health care coverage, Kintegra Health will be notified and such change will be supported by the submission of appropriate documentation.
* Approval of this application is limited to a maximum of (1) year from the date of approval.
* The applicant is at least 18 years old, has been declared by a court to be emancipated, or is emancipated by marriage or other legal definition.
* If the applicant participates in pharmaceutical assistance programs offered by Kintegra Health pharmacy department, permission is given for the pharmaceutical companies or its designees to review records for audit purposes.

I agree that failure to provide proof of income will remove me and my family from the Kintegra Health, Inc. sliding fee scale discount program. I understand that my fees are based on the financial information which I have provided and agree that the information provided is true and includes all household income. I agree to notify Kintegra Health, Inc. of any and all changes to my insurance status and/or household income.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant or Parent/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kintegra Health Witness Signature Date

**REFUSAL WAIVER (for patients who do not want to apply for Sliding Fee Discounts)**

* I have been given the opportunity to apply for Kintegra Health’s sliding fee discount program, and I DO NOT WISH TO APPLY FOR THE SLIDING FEE DISCOUNT PROGRAM AT THIS TIME. Because you do not wish to apply or comply with the requirements to apply for sliding fee discount program, you are choosing to be a self-pay patient. This means that you will pay $80.00(Medical/BH)/$150 (Dental)/$60 (Chiropractic) at the time of service. This is a minimum required payment. Additional charges may apply depending on the services rendered. You will be responsible for any and all balances due after the charges for your visit are entered.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (First, Middle, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total in Family Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Adults \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Health Insurance or Medicaid? YES \_\_\_\_\_\_ NO \_\_\_\_\_\_ If yes, What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acceptable Income Documents:**

* Pay stubs or Statement of Income from employer for last 30 days of employment listing gross wages before taxes.
* Unemployment Compensation Determination Letter from Employment Security Commission.
* Award Letter for Disability, SSI, SSD, or other government assistance resources.
* Court documents or bank statements showing deposits of child support or alimony payments.
* Most recent tax returns.
* Food Stamp Verification Letter
* Self-Declaration of Income Form (only if there is no other way to document your income).

**HOUSEHOLD SIZE AND INCOME: Household** is defined by Kintegra Health as the taxpayer plus his/her dependents. If you file jointly then you will need ot supply income for both taxpayers. A copy of the most recent tax return is recommended**.**

|  |  |  |
| --- | --- | --- |
| **Verification Checklist** | YES | NO |
| **Identification/Address**: Driver’s license, utility bill, employment ID, Passport |  |  |
| **Income Documents:** Pay Stubs, Tax Returns, SS/Disability/Unemployment, Food Stamps, Employer Statement, Self-Declared Income form, other… |  |  |
| **Medicaid Coverage Verification** |  |  |
| **Patient Message & FYI completed.** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **WEEKLY** | **BI-WEEKLY** | **SEMI-MONTHLY** | **MONTHLY** |
| **1.** | **1.** | **1.** | **1.** |
| **2.** | **2.** | **2.** |  |
| **3.** |  |  |  |
| **4.** |  |  |  |
| **Total**  | **Total** | **Total** | **Total** |
|  **X13** |  **X13** |  **X12** |  **X12** |
| **Total**  | **Total** | **Total** | **Total** |

**Eligibility Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eligibility End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **FPL %\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay \_\_\_\_\_\_\_\_\_\_\_\_\_\_ PPE Tier \_\_\_\_\_\_\_\_\_\_\_\_ ( ) No PPE**

**For Office Use Only**

**Reviewed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **First Name/Last Name** **of all household members** | **Relation** | **Date of Birth** | **INCOME** | **Circle One** |
|  |  |  | **$** | Weekly Bi-WeeklyMonthly Annually |
|  |  |  | **$** | Weekly Bi-WeeklyMonthly Annually |
|  |  |  | **$** | Weekly Bi-WeeklyMonthly Annually |
|  |  |  | **$** | Weekly Bi-WeeklyMonthly Annually |
|  |  |  | **$** | Weekly Bi-WeeklyMonthly Annually |
|  |  |  | **$** | Weekly Bi-WeeklyMonthly Annually |

**Medication Assistance Program Guidelines**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Obtaining medications through the Medication Assistance Program (MAP) is a gift and cannot be guaranteed to be available or to arrive on time. It is your responsibility to obtain your own medications if this happens. Drug companies as well as KINTEGRA HEALTH reserve the right to remove medication from their program at any time.

If you filed taxes within the latest taxable year we require your 1040 forms. If you did not file and were not claimed as a dependent on someone else’s tax forms we will need you to sign a 4506 T form stating this. If neither of these apply to you, we need copies of the most recent paychecks verifying household income for the last month. If there is no household income we will need you to file for Medicaid and bring us a denial letter stating you cannot be covered on Medicaid and a letter of who is supporting you.

Once you have been approved for MAP and to remain active you must notify both the MAP and Pharmacy offices of any changes made to medication, household income, address, phone numbers, or if you obtain insurance or Medicaid. When initially enrolled it could take up to 8 weeks or longer for meds to arrive (although the drug company could mail you notification that they have already shipped we still have to process the medication in our system). KINTEGRA HEALTH must receive all meds shipped directly to us to ensure you of an accurate reorder date. However, you must notify us if they are shipped to your home by mistake. Also it is very important for you to call us if you receive any paperwork in the mail from the drug company.

When your medications are ready to be picked up you will receive an automated phone call from the pharmacy. The medications that you receive through MAP are free but there will be a $6.00 processing fee to be paid to the pharmacy for each 90 day supply at the time of pickup. You will have 30 days to pick up your medicine or it will be returned to stock and you can be discharged from the program for being non-compliant.

To be eligible to receive medication through MAP we require you signature giving us permission for us to: Sign your name on applications and letters from prescription assistance programs only; attest that you do not have insurance, Veterans Affairs or Medicaid and that you will notify us of any changes in your circumstances.

If you have any questions or concerns in relation to the Medication Assistance Program please contact the Community Resource Advocate at your Clinic.

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature Date

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Kintegra Health Witness Signature Date