APPLICATION FOR DISCOUNTED SERVICES

Patient Name: _____ Date of Birth:_____

Phone:_____

Additional Members of Family/Household who are patients of UNC Health Complete Care:

Patient Name: _____ Date of Birth:_____

Patient Name: _____ Date of Birth:_____

Patient Name: _____ Date of Birth:_____

Patient Name: _____ Date of Birth:_____

Patient Name: _____ Date of Birth:_____

I. SLIDING FEE SCHEDULE

As a Federally Qualified Health Center, UNC Health Complete Care offers a sliding fee discount schedule for those who qualify. You may receive the discounted rate even if you have private insurance, Marketplace insurance, or Medicare, if the discounted rate is lower than your normal out-of-pocket cost. If you are not eligible for the sliding scale, choose not to apply, or do not provide household and income information, you will be expected to pay the full charge for care.

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II. ELIGIBILITY VERIFICATION:

How many people live in your household? _____

Gross income: Please list your household's gross income (the $ amount received before taxes are taken out). Household income includes everyone in the home.

Combined gross income: _____ Frequency: _____

How are you providing proof of income?

- ☐ Check Stubs
- ☐ W-2
- ☐ Letter of Support
- ☐ Self-Declaration
- ☐ Social Security Statement

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Consent for Application for Discount Services

I understand that this information is to be used to determine eligibility for the UNC Health Complete Care Sliding Fee Discount Schedule. I understand that a UNC Health Complete Care official may verify information on this form. I understand that the application will only be valid for 6 months unless proof of income is provided, self-declaration can only be approved once every 12 months. I certify that the information provided above is accurate and complete to the best of my knowledge. In the event of a change in income or insurance coverage, I will notify UNC Health Complete Care at my next appointment. I understand that I will be financially responsible for all or a portion of my care and that I will be asked to submit payment at the time of service. I authorize the release of any information necessary to establish my family's eligibility for discounted services and I give my consent to release my information to pharmaceutical companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may be enrolled.

I understand that UNC Health Complete Care uses Epic as the electronic medical record system and I consent to have the above information stored in my electronic medical record.

Patient Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Sliding Fee Scale Plan (A-E): _____