Shawnee's Financial Assistance Program Application

Patient Name:_____

DOB:_____

Date:_____

Because we are a Community Health Center, we have the opportunity to offer a discount on your services based on your family size and adjusted gross income. This discount is available to all patients who are uninsured or under-insured. If you feel this may be a benefit to you and your family, please complete this Application and provide the following documentation.

The following items are required:

- **Proof of Identification**
- **Proof of Family Size (Application or if available verify using the Tax Return)**
- **Proof of Family's Adjusted Gross Income (AGI)**

  Preferred method is the most recent Tax Return

  If unavailable or you have a different job then the job reported on the most recent taxes, then you can use the most recent paycheck stubs (for the last 30 days) from your current employer

  If you receive social security benefits and taxes are not available a copy of the benefit letter must be obtained

  The last resort is the SHS Income Attestation Form, however it must be for one of the approved reasons listed below

Only to be used if a most recent tax return or paycheck stubs are not available or appropriate:

- **Attestation** - Patients may complete an Attestation form to prove income if they meet one of the following criteria:
  - Unemployed family members financially supported by another family member or individual
  - Adults who work seasonally or intermittently
  - Adults paid in cash
  - Adults whose only source of income is SSA/Disability benefits
  - Homeless, living in a shelter

Shawnee Health Service

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Patient Name:___________________________________

Are you applying for yourself or are you applying for yourself and other members of your family?
☐ **Patient Only** ☐ **Patient and Family Members**

Please verify and complete the below information:

Name:____________________________ **Date of Birth:**_____________________

Address:____

Other Name(s) Used: ______________________________________

FAMILY MEMBERS WHO ARE INCLUDED IN YOUR HOUSEHOLD:
Your family is what you claim on your tax return. Complete the table below. Attach documents (birth certificate, divorce papers, marriage license, foster or guardianship paperwork) if there have been changes since the tax return. If you are pregnant, please add "unborn child" to this list.

Family Member_________________________________ **Relation:**_____________________ **Date of Birth:**________________
Employed: ☐ Yes ☐ No **SIU Student:** ☐ Yes ☐ No **Medical Insurance/Medicaid:** ☐ Yes ☐ No
Dental Insurance: ☐ Yes ☐ No **Applying for this family member:** ☐ Yes ☐ No

Family Member_________________________________ **Relation:**_____________________ **Date of Birth:**________________
Employed: ☐ Yes ☐ No **SIU Student:** ☐ Yes ☐ No **Medical Insurance/Medicaid:** ☐ Yes ☐ No
Dental Insurance: ☐ Yes ☐ No **Applying for this family member:** ☐ Yes ☐ No

Family Member_________________________________ **Relation:**_____________________ **Date of Birth:**________________
Employed: ☐ Yes ☐ No **SIU Student:** ☐ Yes ☐ No **Medical Insurance/Medicaid:** ☐ Yes ☐ No
Dental Insurance: ☐ Yes ☐ No **Applying for this family member:** ☐ Yes ☐ No

Family Member_________________________________ **Relation:**_____________________ **Date of Birth:**________________
Employed: ☐ Yes ☐ No **SIU Student:** ☐ Yes ☐ No **Medical Insurance/Medicaid:** ☐ Yes ☐ No
Dental Insurance: ☐ Yes ☐ No **Applying for this family member:** ☐ Yes ☐ No

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Agreements: By Signing below, I agree that:

- I certify that the information I provided is true and correct to the best of my knowledge. I understand that if the information I provided is determined incorrect, the discount will be denied.
- I have completed and attached all required documentation.
- I understand that it may take two (2) business days to process my application
- I agree to inform Shawnee if there are changes to my income, household size or insurance coverage.
- I understand that certain services and/or items cannot be discounted.
- I agree to pay a nominal fee at the time of service.
- I understand an auditor of any patient assistance program that I may benefit from may review the information.
- If receiving medication through the Pharmaceutical Assistance Program, I give permission to Shawnee Health Service and Development Corporation to sign patient assistance applications for me to order my medication. This consent is valid as long as I am a patient of Shawnee Health Service and Development Corporation, or until I revoke my permission in writing.

Applicant Signature:_____ **Date:**_____

Interpretation Provided by:_____

Shawnee Health Service

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Patient Name:_____

SFA Attestation
Complete Any Applicable Item Below

1. If someone else helps support you, please list the names and their relationship. Have that individual who supports you complete the following information.

Name of the individual:_____ Relationship to you:_____

Type of support provided (housing, food, clothing, transportation, etc.):_____

Telephone:_____ Date: _____

2. ☐ I am unemployed ☐ I am paid in cash ☐ I work intermittently ☐ I am a seasonal farmworker
☐ I do not file taxes because my only source of income is Social Security/Disability Benefits
☐ I do not files taxes because I do not make enough money
☐ I am living off of my savings account
☐ I don't have a full 30 consecutive days worth of paycheck stubs

2. Electronic Verification of Income:
☐ Website
☐ Payroll
☐ Bank Statement

Amount Verified: $ _____

4.Other: (Must be approved by Revenue Cycle Director)
_____

AGREEMENTS: By signing below, I agree that:

• I certify that the information I provide is true and correct and that if the information proves to be incorrect, the discount will be denied.
• I understand the information ma be reviewed by an auditor of any patient assistance program that I may benefit from.

Applicant Signature:_____ Date:_____

Signature of Individual that monetarily supports you (if applicable):_____ Date:_____

Shawnee Health Service

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OFFICE USE ONLY

☐ **Patient Declined Medicaid Assistance**

☐ **Attempted collection of Prior Year's Taxes**

- If unavailable list reason why:_____

- If they don't file taxes because they don't make enough money, what is their annual income? $_____

☐ **Attempted collection of last 30 days paycheck stubes (consecutive)**

- If unavailable list reason why:_____

- Remind the patient to return the remaining 30 days worth of paycheck stubs once received.

☐ **Attempted collection of social security benefit letter**

- If unavailable you MUST verify the benefit amount by calling Social Security Office

Date Called:_____

Spoke to:_____

Amount Verified: $_____

Total Annual Benefit $_____

☐ If paid in Cash

- Verify Employer Name:_____

Amount Paid Monthly: $_____

☐ **Ran eligibility for Medicaid and offered Case Management assistance to enroll (if applicable)**

☐ - Patient ineligible_____

☐ - Patient declined_____

☐ **Appointment made with Case Management to provider additional assistance**

☐ Appointment Date:_____

By signing below, I certify that:
I exhausted all other means of income verification prior to completing the income attestion form with the patient.

Staff Signature:_____ **Date:**_____

Supervisor Signature:_____ **Date:**_____

Interpretation Provided By:_____

Shawnee Health Service

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Income Calculation Worksheet

OFFICE USE ONLY

1. Frequency of Pay - Circle Below

- Monthly - 12 pay periods - Once a Month (1st of the month)
- Semi Monthly - 24 pay periods - Same two days each month (15th and 30th of the month)
- Weekly - 52 pay periods - Once a Week, Same Day (every Saturday)
- Biweekly - 26 pay periods - Set day of the week (every other Friday)
- School Year - Prorated - Get taxes to see if they work during the summer of have another job

2. Paycheck Stubs - Gross Pay Amount

1. $_____

2. $_____

3. $_____

4. $_____

Total Amount ($) of Paychecks / Number of Paychecks Provided = Average Paycheck

$_____ / _____ = $_____

3. Calculate Annual Gross Income

Average Pay Check X Frequency of Pay = Annual Gross Income

$_____ / _____ = $_____

4. Additional Comments:_____

Shawnee Health Service

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FOR OFFICE USE ONLY
Collect from the Applicant:

- Identification for each family member (18+) seeking discount
- Proof of Family Size (Previous Year's Tax Return/Attestation if available)
- Proof of Adjusted Gross Income (Preferred Method is Previous Year's Tax Return

Calculate Family Size:_____ **Verified With: Taxes / Application**

Calculate Family's Adjusted Gross Income:

Source:_____ Annual Amount: $_____

Source:_____ Annual Amount: $_____

Source:_____ Annual Amount: $_____

Source:_____ Annual Amount: $_____

Total Annual Family Adjusted Gross Income: $_____

Discount Level:

Family Member Name(s):	Eligible for slide Level:	Effective/Expiration Dates:
	A B1 B2 B3 B4 C	
	A B1 B2 B3 B4 C	
	A B1 B2 B3 B4 C	
	A B1 B2 B3 B4 C	
	A B1 B2 B3 B4 C	
	A B1 B2 B3 B4 C	

	Level A 100% and Below	Level B1 101% - 125%	Level B2 126% - 150%	Level B3 151% - 175%	Level B4 176% - 200%	Level C Over 200%
Family Size 1	$0 -12,880.00	12,880.01-16,100.00	16,100.01-19,320.00	19,320.01-22,540.00	22,540.01-25,760.00	25,760.01 & above
Family Size 2	$0-17,420.00	17,420.01-21,775.00	21,775.01-26,130.00	26,130.01-30,485.00	30,485.01-34,840.00	34,840.01 & above
Family Size 3	$0 -21,960.00	21,960.01-27,450.00	27,450.01-32,940.00	32,940.01-38,430.00	38,430.01-43,920.00	43,920.01 & above
Family Size 4	$0 -26,500.00	26,500.01-33,125.00	33,125.01-39,750.00	39,750.01-46,375.00	46,375.01-53,000.00	53,000.01 & above
Family Size 5	$0-31,040.00	31,040.01-38,800.00	38,800.01-46,560.00	46,560.01-54,320.00	54,320.01-62,080.00	62,080.01 & above
Family Size 6	$0 -35,580.00	35,580.01-44,475.00	44,475.01-53,370.00	53,370.01-62,265.00	62,265.01-71,160.00	71,160.01 & above
Family Size 7	$0 -40,120.00	40,120.01-50,150.00	50,150.01-60,180.00	60,180.01-70,210.00	70,210.01-80,240.00	80,240.01 & above
Family Size 8	$0 -44,660.00	44,660.01-55,825.00	55,825.01-66,990.00	66,990.01-78,150.00	78,150.01-89,320.00	89,320.01 & above

Family Size over 8? Add $4,540 for each additional person

How was the patient notified of discount level? Face to Face / Mailed Letter

Chart Documentation Check List:

☐ ID(s) on file in Athena
☐ Annual Family Size Updated
☐ Annual family gross income updated
☐ Scanwich for each family member completed
☐ Patient refused ACA Appointment (mark if applicable)

Staff Signature:_____ **Date:**_____