Bear Lake Community Health Centers

Sliding Fee Scale Application

The Mission of the Bear Lake Community Health Centers is to provide access to quality primary and urgent health care for the residents and visitors of the Bear Lake, Evanston, Cache Valley and surrounding communities on an ability-to-pay basis. The center will take a holistic approach to maintaining a healthy community through education, prevention, and a community networking system.

Thank you for choosing the Bear Lake Community Health Centers to serve you and your family's healthcare needs. Our services include medical, dental, and behavioral health. We are federally qualified health centers which enable us to offer all of our patients a sliding fee scale. The sliding fee scale is a financial program for families and individuals based upon household size and annual income. Additionally, the pharmacy offers special pricing for the patients of Bear Lake Community Health Centers.

Please complete this form and attach proof of income for all household members at least 24 hours prior to your first date of service. Proof of income includes:

- Most recent paystubs for one month or written statement from employer

AND

- Current tax information

If you are not able to provide both of the above, then bank statements showing income deposits for the past two months may be provided instead. If you are not able to provide two of the required documents, then you must fill out the Proof of Income letter on the last page of the application. You will also be required to submit a letter from the person who supports you. At least one of your documents must include proof of your current address.

Once your application has been received, you must come to the office for an interview to review your application and discuss your qualification to complete the process.

If your application is accepted it will be valid from 3 months to one year, depending on your current financial situation. At the end of that time it will be your responsibility to reapply and provide all documentation in order to re-evaluate your level of financial need. If there are any changes to your income, family status, or location during that approved time frame, it is your responsibility to notify the Bear Lake Community Health Centers.

If you have any questions or concerns regarding your application, please call **(435)755-6061** and ask to speak to a private-pay billing representative. You may send your completed application to:

BEAR LAKE COMMUNITY HEALTH CENTERS
1515 North 400 East, Suite 104, Logan, UT 84341
or fax to (435)755-6091

Received Date: _____
Received By: _____
Approved Slide Level: _____
Approved By: _____
Approved Dates: _____
Letter Sent: _____
Account #: _____

BEAR LAKE COMMUNITY HEALTH CENTERS

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Please list and provide proof of **all** sources of **gross** income earned by your family in the past month and attach proof of income, which includes current tax returns, most recent paystubs for one month, written statement from your employer, or two months bank statements showing income. If you are not able to provide two of the needed items, please complete Proof of Income Letter on the next page. All information provided will be kept confidential.

1. General Information

☐ New Applicant ☐ Change in Income ☐ Renewal

Name:_____

Home/Mailing Address:_____

City:_____State:_____Zip:_____

Home Phone: (___)_____ Cell Phone: (___)_____

2. Household Information

Starting with yourself, list all dependents living in your home.

Name	Relation	Date of Birth (MM/DD/YY)	Sex (M/F)	Marital Status	Employer
	SELF				

3. Income

List all income received by all those living in the home. Income can include; alimony, child support, unemployment, social security, pensions, etc.

Gross Earnings (i.e. $900/mo. or $8/hr.)	**Unemployment Benefits, Workers Comp.**	**Welfare**	**Child Support, Alimony**	**Social Security, Pension**	**Other Income** (Dividends, Rental Income, Etc.)
$ /					
$ /					
$ /					
$ /					
$ /					

Total Earnings: $_____

4. Other Information

1. Do you presently have medical insurance, Medicare or Medicaid? ☐ Yes ☐ No

   If **yes**, list insurance name & ID #. Policy Name:_____ ID #:_____

   Deductible: $_____

2. Do you presently have dental insurance? ☐ Yes ☐ No

   If **yes**, list insurance name & ID #. Policy Name:_____ ID #:_____

3. Do you presently have a Health Savings Account (HSA)? ☐ Yes ☐ No

   If **yes**, please answer the following question:

   3A. What is your current HSA balance? $_____ (Please give your best estimate)

   3B. What is your current monthly HSA deposit amount? $_____

4. What is the dollar amount of your current bank account? (Please give your best estimate.)

   Checking Account: $_____

   Savings Account: $_____

   Other $_____

5. Have you applied for Utah/Idaho/Wyoming Medicaid? ☐ Yes ☐ No ☐ Denied

6. Are you interested in applying for Medicaid assistance? ☐ Yes ☐ No

   If **yes**, please answer the following question:

   6A. Are you a U.S. Citizen or Legal Alien? ☐ U.S. Citizen ☐ Legal Alien ☐ Illegal Alien

Please use the self-attestation box below to explain, in detail, any circumstances restricting you from providing required information regarding employment, proof of any and all income, or any special accommodations made regarding your current financial situation, including but not limited to;

- You are self-employed and do not issue paychecks to yourself
- You have not filed your taxes
- You are currently unemployed
- You are receiving support from another person
- You do not have a bank account

Self-Attestation Statement Anything written here you affirm is correct, true, and genuine.
_____ _____ _____ _____ _____ _____ _____ _____

If you are not able to provide proof of income due to unemployment, please list below how you are able to support yourself and your family. You will also be required to submit a Proof of Support letter completed by whoever provides the majority of your support.

Rent	
Food	
Utilities	

5. I Understand that:

- I am financially responsible for all medical, dental, and behavioral health services rendered, including lab fees or referrals that are sent out of Bear Lake Community Health Centers to be tested.
- I affirm that the information I have provided is an accurate statement of income and location at the time of application. I understand that a person who obtains or attempts to obtain, by fraudulent means, services to which he/she is not entitled may be prosecuted under applicable state and federal laws. I agree to report any changes to my income, family status, or location to the Bear Lake Community Health Centers.
- As necessary, the information on this application may be used to determine Medicaid eligibility.
- I understand that the program is subject to change without notice.

Signature: _____ Date: _____