PLEASE FILL OUT ALL SECTIONS

WellOne Primary Medical and Dental Care

Application to Receive Reduced Fee Medical, Behavioral Health, and Dental Services (Long-Form)

Applicant's Information:

Name	*DOB*	*SS# (optional)*
_____	_____	_____

Phone Numbers ***Address***

Home Phone:_____ _____

Cell Phone:_____ _____

Please List all Family Members; ***excluding patient listed above (see back of form for guidance)***

Name	*DOB*	*Relationship*	*SS# (optional)*	*Included in this Reduced Fee Application (Yes or No)*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you currently employed? ***Yes*** _____ ***No***_____

Do you collect unemployment? ***Yes*** _____ ***No***_____

Do you receive SSI, SSDI, or other forms of disability payments? ***Yes*** _____ ***No***_____

Are you currently receiving payments from any retirement plans, IRA's, or SS? ***Yes*** _____ ***No***_____

Do you have Medical Insurance? (A) ***If yes, Insurance Name***_____ ***No***_____

Do you have Dental Insurance? (A) ***If yes, Insurance Name***_____ ***No***_____

Did you file a Federal income tax return for the prior calendar year? ***Yes*** _____ ***No***_____

Office Use Only

Income:_____

 # in Household:_____

Level A B C1 C2 D

Original RF Date:_____

Date Letter Sent:_____

Approved by:

(CONTINUED ON OTHER SIDE)

(A) A patient's insurance status is not a determining factor for program eligibility.

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Terms and Conditions

1. A reduced fee schedule (also referred to as sliding fee scale) is available to qualifying patients of WellOne Primary Medical and Dental Care.
2. Fees for most services may be reduced to a nominal level as defined by WellOne Primary Medical and Dental Care's Board of Directors.
3. Both uninsured and insured patients shall be eligible for reduced fees.
4. Uninsured patients who satisfy eligibility criteria will be strongly encouraged to apply for health insurance coverage through Medical Assistance (including the State's Rite Care Program) or other state programs including the Women's Cancer Screening Program.
    a. Eligible patients may be referred to an Agency's Official for enrollment into the applicable state program.
5. Family is defined as a group of two or more people (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Family is also defined as any form of non-married spousal coupling, with or without dependent children.
6. Co-pays, coinsurance, and deductibles of insured patients are eligible for reduced fee discounts under this program.
7. Patients must complete the application and submit all financial documentation requested to become eligible for reduced fee services. A new long-form application must be completed every two years. A short-form reduced fee application should be completed for interim years.
8. Patients who refuse to comply with the application and verification of income processes may not be eligible for reduced fee services at WellOne.
9. Payments for services (including nominal fees) are required at the time services are rendered. Patients who do not comply with this policy may become ineligible for services at WellOne Primary Medical and Dental Care.

I, _____ am applying for reduced fee services at WellOne Primary Medical and Dental Care. I have reviewed and understand the above terms and conditions and agree to comply with them. I certify that I have fully disclosed my health insurance policy information. The information contained in the accompanying application is accurate and complete to the best of my knowledge and belief. I agree to notify WellOne should my insurance, income, or family situation change in a manner that may affect my eligibility for reduced fee services. I understand that intentional falsification of information provided herein or the omission thereof constitutes fraud and may be punishable as a crime in accordance with applicable laws and regulations.

_____ _____

Applicant's Signature **Date**

List of Documentation Needed with application

1. **Completed Application.**
2. **Copy of Most Recent Federal Income Tax Return (no W-2's please).**
3. **Copy of Income Documentation including SSI, SSDI, Workers Compensation, Pensions, Garnished Wages, most recent Paystub.**
4. **If you are not working or collecting any income, you must supply a written letter from individual(s) supporting the patient.**
5. **Included with letter (item 4), an Applicant's Affidavit, which can be obtained at WellOne.**