

NORTHEAST MISSOURI HEALTH COUNCIL, INC.

PATIENT/INSURED RESPONSIBILITY

It is the responsibility of the patient/insured to be sure the information we have is current and accurate. Please advise our staff when there is a change in any of the information we have on file relevant to providing your care/billing correctly. It is our desire to serve you to the best of our ability and your assistance in providing us with all relevant information is essential to this goal. We thank you for selecting our staff to provide you with the care that you deserve.

SLIDING FEE DISCOUNT PROGRAM

The Sliding Fee Discount Program is designed to help make healthcare services more affordable for patients at clinics operated by the Northeast Missouri Health Council, Inc. Most services are covered by the Sliding Fee Discount Program.

The sliding fee discount program can reduce applicable charges for qualified patients. All patients utilizing Sliding Fee Discount program must pay the minimum amount of \$25.00 (effective July 1, 2005), plus any co-pay, at time of service. An application must be completed in full, and income level verified, to qualify for the program. The program is based solely on family size and income, so patients can apply regardless of insurance coverage. A slide card showing eligibility is provided to qualified applicants upon completion of the necessary documentation.

All third party billing will be initiated and sliding fee discounts will be applied to the balance after insurance reimbursement has been made. The patient will not be expected to pay more than the minimum amount due as determined by the slide category for which they qualify. Any insurance payment for services covered by the slide discount that are sent to the insured should be reimbursed to NMHC, Inc.

No sliding fee discounts are granted until the application process is completed and the application has been approved.
Be advised that sliding fee discounts do not apply to all services.

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

APPLICATION FORM

Identifies: 1. MEMBERS IN THE HOUSEHOLD
2. DATES OF BIRTH AND SOCIAL SECURITY NUMBERS
3. TOTAL INCOME INTO THE HOUSEHOLD

PROOF OF INCOME FOR THE HOUSEHOLD

1. IRS 1040 INCOME TAX FORM PREFERRED
2. COPY OF MOST RECENT PAYSTUB OR CHECK for all income.
3. TWO LETTERS REQUIRED FROM NON-FAMILY MEMBERS, IF YOU HAVE NO INCOME.

Applications made at any time during the fiscal year are effective for 30 days prior to completion of the slide. Patients should apply or reapply when the fiscal year changes or when family size or income have changed. One application per family is all that is required to receive the Sliding Fee Discount at any of the clinics operated by the Northeast Missouri Health Council, Inc. New information must be submitted each fiscal year. (04/01 thru 03/31)

For more information or a program application, please inquire at any NMHC, Inc. Clinic or Business Office.

FRONT OF FORM

**NORTHEAST MISSOURI HEALTH COUNCIL, INC.
BILLING AND COLLECTIONS POLICY**

The Northeast Missouri Health Council, Inc.'s (NMHC) Payment Policy states,
"**...payment is due at the time service is provided**".

NMHC CLINICS ARE NOT FREE CLINICS

All co-payments deductibles, and/or other patient financial responsibilities are due and payable at the time the service is provided, unless suitable arrangements for payment have been established with the NMHC's clinic staff.

As a courtesy to patients, NMHC will file claims according to the guidelines specified by individual health plans, provided complete and accurate information has been obtained from the patients. If a NMHC healthcare provider does not participate with a patient's specific health plan, payment is due from the patient (or other identified responsible party), in full, at the time the service is rendered. Patients are responsible to inquire about the limitations of their own specific health plan(s).

As a Federally Qualified Health Center, NMHC, Inc. can offer discounts for various services, once patients complete the proper application and eligibility has been determined. Eligibility for the Sliding Fee Discount program is based solely on family size and income. NMHC may be able to suggest additional funding sources to assist patients with their financial responsibility for healthcare services.

The review of a patient's ability to pay for services at NMHC clinics is not based solely on the U.S. Department of Health and Human Services Income Poverty Guidelines and corresponding schedule of discounts. Rather, a patient's ability to pay for services is determined utilizing a standardized evaluation of information provided by patients regarding their economic status and personal circumstances.

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

Please be advised that the Northeast Missouri Health Council, Inc. (NMHC, Inc.) does not file liability insurance (such as motor vehicle or accidents involving other insurance plans) other than for the patient's own accident coverage. NMHC, Inc. will furnish patients with available information to file their own claims for these cases. It is the patient's responsibility to advise the NMHC, Inc. staff of this situation to avoid filing of patient's medical insurances in error.

All accounts due by the patient are considered past due if not paid within 30 days of services. Patients will be initially notified of the amount due at the time services are rendered, when possible. A monthly statement will be sent to each account reflecting an amount due by the patient. Payment contracts can be established at the NMHC, Inc. Business Office for patients who cannot pay for services in full. If no response is received from the patient billing, a pre-collection letter will be mailed advising the account is past due. Accounts that have not had payment activity from the patient (or responsible party) for 60 days from the time of service was determined to be the patient's responsibility will be considered delinquent. Collection procedures will be initiated immediately against delinquent accounts. If it has been determined that a patient (or responsible party) has failed to respond, or has inadequately responded, to NMHC's collection efforts, the amount due will be referred to an outside agency for collection. Once a patient balance is referred to a collection agency, the patient (or responsible party) will communicate with the collection agency regarding the amount due. Further, NMHC will advise the patient's clinic and healthcare provider that services for that patient may be restricted to a cash only basis. Dismissal from the practice will be considered if NMHC determines that the patient has the ability to pay for services, but refuses to make acceptable payment arrangements. Past due balances will be subject to interest as is applicable per the current policies. Payment arrangements are reflective of the amounts agreed upon under contractual arrangements and do not dismiss the patient or responsible party from being responsible for payment of other services rendered, not specifically outlined in the payment contract(s).

This Billing and Collection Policy was adopted by the Northeast Missouri Health Council Board of Directors

BACK OF FORM

Northeast MO Health Council, Inc.-Admin/Business Office-314 E. McPherson St., Kirksville, MO 63501 660-627-5757 Fax 660-627-6285
Family Practice-Rosewood 660-627-4493 **Jefferson** 660-626-2206 **Edina** 660-397-3517 **Milan** 660-265-1042 **Memphis** 660-465-7037
Obstetrics/Gynecology 660-626-2264 **Pediatrics** 660-627-2229 **VA** 660-627-8387 **Behavioral Health** 660-627-3621 **Dental** 660-626-2741

Patient Information					
Last name	First Name	MI	Date of Birth	SS#	
No/Street Address		City	State	Zip	County
Home Phone	Cell Phone	Work Phone	E-Mail	Number in Household	
				Adults	Children
Gender	Marital Status		Race		
M / F	1-Single 2-Married 3-Unknown 4-Widowed 5-Divorced 6-Legally Separated		1-Asian 2-Black 3-Caucasian 4-Hispanic/Latino 5-Amer Indian/Alaskan 6-Black(NonHispanic) 7-White(NonHispanic) 8-Mutually Defined 9-Other 10-Pacific Islander 11-Native Hawaiian		
Student		Employment Status		Employer	
Full Time Part Time Not a Student		Full Time Self Employed Not Employed Part Time Retired Active Duty		Occupation	
Emergency Contact			Phone	Cell Phone	

Guarantor (Person To Be Billed, If Different Than The Patient)					
Last Name	First Name	MI	Date of Birth	SS#	
No/Street Address		City	State	Zip	Home Phone
				Work Phone	
Employer			Occupation	E-Mail	

Medical Insurance	Policy Holder	Relationship	DOB/SS#	Policy ID	Group ID
1					
2					

Notice of Privacy Practices Acknowledgement
I understand that, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:
Treatment, Payment, and Healthcare Operations. I have received, read and understand your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that the Northeast Missouri Health Council has the right to change its Notice of Privacy Practices from time to time and that I may contact them at any time to receive a current copy.

Patient Signature _____ Date _____

HIPAA Approved Contacts

I hereby authorize the Northeast Missouri Health Council, Inc. to disclose health and/or billing information to the individuals identified below that are involved in my care or payment of care.

Name:	Phone:
Name:	Phone:

May the Northeast Missouri Health Council, Inc leave a message on your answering machine or voicemail regarding scheduled appointments, pre-medication, and instructions for testing and/ or procedures? **YES NO** May we leave a message on your answering machine or voicemail when a parent or guardian needs to accompany a minor to an appointment? **YES NO** May we leave a message on your answering machine or voicemail with information regarding our slide discount program and necessary paperwork if you are a participant? **YES NO**

Patient Signature _____ Date _____

Patient's or Authorized Person's Signature
Assignment of Insurance benefits, Release of Information and Authorization of Treatment. I the undersigned authorize my insurance benefits to be paid directly to the provider of the Northeast Missouri Health Council, Inc. (NMHC, Inc.) for services rendered. I understand that I am ultimately financially responsible for any balance due for approved and covered charges not paid by insurance. I hereby authorize NMHC, Inc to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

Signature _____ Date _____

Please attach all pertinent Insurance ID cards for photocopying.

I would like to complete an application for the Slide Discount Program, to determine eligibility, for a discount on my bill, based on my family size and income. **YES NO**

For Office Use Only:
Collected by initials: _____ Entered by initials _____ Date entered in system _____

N O R T H E A S T

MISSOURI HEALTH COUNCIL, INC.

A Federally Qualified Health Center

314 East McPherson
Kirksville, Missouri 63501

Phone (660) 627-5757 Fax (660) 627-5802

April 1, 2008

To Our Patients:

The Northeast Missouri Health Council offers a discount on select medical and dental services through our Slide Discount Program. This program is based on family size and income and follows the Federal Poverty Guidelines, which are adjusted annually. Patients must reapply annually by completing a new application and verifying household income and it is that time of year again.

The providers and staff at the Northeast Missouri Health Council want to continue to offer discounted medical and dental services to all those who qualify and have therefore made some changes to the application process and payment scale.

The following is a list of the changes to the application process that are effective April 1, 2008:

- Application form completed with applicant's name, DOB, and SS#
- Proof of Household income:
 - Completed 4506-T form
 - Completed application including, applicant's names, DOB, SS#
 - Copy of 2006 Tax form, or
 - W-2, Pay stubs for all income for 1 month, 2 letters verifying no income from non-family members, if self employed then an accounting of income or quarterly tax statements, social security patients either by income tax return or remittance or bank statements showing monthly social security income.
 - A completed and qualifying slide application will only be retroactive **30 days**.

The following is a list of the changes in the payment scale effective April 1, 2008:

- Slide 1-\$25 Co-pay plus 10% of balance
- Slide 2-\$25 Co-pay plus 20% of balance
- Slide 3-\$25 Co-pay plus 40% of balance
- Slide 4-\$25 Co-pay plus 60% of balance
- Slide 5-\$25 Co-pay plus 80% of balance

Attached is the required paperwork to be completed by you and returned to our staff. When all required paper work is completed, we will notify you as to whether or not you qualify for the slide discount.

If you have any questions regarding this process, please ask someone at the clinic or contact our business office personnel at 660-627-5757.

"Dedicated to Serving, Committed to Caring"

As a Federally Qualified Health Center (FQHC) we are required to report social and economic data on our patients, to meet federal requirements for grant funding of our program. Please complete this form to the best of your ability, then sign and date. NMHC appreciates your cooperation, and want to assure you that we only report de-identified (no names or medical information) data.

Patient Name: Last _____	First _____	MI _____
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Primary language spoken: English Spanish Other, please specify _____

Do you require interpretive services? YES NO

Are you a Veteran? YES NO

Please find your family size, then circle the income range that reflects your household income.

Family Size	INCOME LEVELS FOR POVERTY LEVEL REPORTING					
	1	0-10,400	10,401-13,000	13,001-15,600	15,601-18,200	18,201-20,800
2	0-14,000	14,001-17,500	17,501-21,000	21,001-24,500	24,501-28,000	28,001-Above
3	0-17,600	17,601-22,000	22,001-26,400	26,401-30,800	30,801-35,200	35,201-Above
4	0-21,200	21,201-26,500	26,501-31,800	31,801-37,100	37,101-42,400	42,401-Above
5	0-24,800	24,801-31,000	31,001-37,200	37,201-43,400	43,401-49,600	49,601-Above
6	0-28,400	28,401-35,500	35,501-42,600	42,601-49,700	49,701-56,800	56,801-Above
7	0-32,000	32,001-40,000	40,001-48,000	48,001-56,000	56,001-64,000	64,001-Above
8	0-35,600	35,601-44,500	44,501-53,400	53,401-62,300	62,301-71,200	71,201-Above

For families with more than ten (8) members, add \$3,600 for each additional member.

WOMEN AND CHILDREN ONLY

Are you a WIC enrollee?	YES	NO
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PRENATAL/OB CARE

If you are currently pregnant, were pregnant any time this year, or delivered this year, and you receive(d) prenatal, delivery, or post partum care from NMHC providers (Dr. Carr, Dr. Solovieva, Gina Gilliland, Alice Davis, Dr. Davis/Jami Dalton/Margaret Mishra(Memphis), then please answer the following questions:

Age _____

Race	Asian	Native Hawaiian	Other Pacific Islander	Black-Not Hispanic/Latino
	Amer Indian/Alaskan	White-Not Hispanic/Latino	Hispanic/Latino	Mutually Defined

In what trimester did you start prenatal care?

1	2	3
0-14 wks	15-28 wks	29-40 wks

Birth weight of baby (delivered this year) _____ lbs _____ oz

Race of Baby

Asian	Native Hawaiian	Other Pacific Islander	Other Pacific Islander
Amer Indian/Alaskan	White-Not Hispanic/Latino	Hispanic/Latino	Mutually Defined

Signed: _____ Date: _____

NORTHEAST MISSOURI HEALTH COUNCIL, INC.
APPLICATION FOR SLIDING FEE SCALE DISCOUNT

AR-1 B

effective date: 4/1/2008

The Northeast Missouri Health Council, Inc. may be able to offer services at a discounted price based on the number of members in your household and their combined income. If you wish to determine the amount of discount available to you, the following information is required. Information reported should be as accurate and complete as possible and will be kept completely confidential.

The total number of applicants is _____

	NAME, LAST	FIRST	MIDDLE	BIRTH DATE	AGE	SS NUMBER	RELATIONSHIP TO APPLICANT
1							
2							
3							
4							
5							
6							
7							
8							
9							

The annual verified income is \$ _____

X	Proof of Income Documents	Date Received by Clinic
	(1) Income Tax Return (Adjusted Gross Income IRS 1040 (line 36), 1040A (line 21), 1040EZ (line 4))	
	(2) Completed IRS Form 4506-T	
	If patient did not file a tax return, then ONE of the following must be provided <u>along with the completion of IRS Form 4506-T</u>:	
	(1) Copy of most current W-2 (use the figure in 'Box 1' for total patient income)	
	(2) Copy of pay stubs (for all incomes for a minimum of 1 month)	
	(3) Self-employed individuals must provide some accounting of income or quarterly tax payments	
	(4) Two letters from non-family verifying that the patient has no income (See Attachment XXX)	

You will be issued a slide card. This card is valid until the end of the current fiscal year (3/31) or until your living/financial situation changes. **YOU MUST PRESENT THIS CARD AND PAY YOUR CO-PAY EACH TIME YOU VISIT THE CLINIC.** Your discount will apply to all of our clinics, but not all services are covered by the sliding fee program. Please inquire before services are rendered if you need to be informed of covered services. If you have insurance, your signature on this form is our release to file your insurance for the full amount of services rendered. The clinic is entitled to recoup the full amount charged from insurance and will slide off the balance only after all insurance payments or denials have been received and posted.

If proof of income is not obtained and the slide application is not completed within **30** days of the service, the patient must pay full charge. This application qualifies the individuals listed above for the slide category determined for the entirety of the current fiscal year applicable by the date the application is completed. Our fiscal year is from April 1st through March 31st. A new application must be completed annually.

I have read and understand all of the preceding information. I certify all information recorded as being accurate, truthful and complete. If there is a change in the number of applicants or my financial situation changes, I will contact the clinic immediately and re-apply if necessary.

Date

Applicant's Signature

Co-Applicant's Signature

SLIDE CATEGORY _____

Completed by: _____
Signature of NMHC, Inc Staff Date: _____

SLIDING FEE SCALE REQUIREMENTS

APPLICATION FORM IDENTIFYING THE
APPLICANTS' NAMES
DATES OF BIRTH AND **SOCIAL SECURITY NUMBERS** AND
TOTAL INCOME FROM 1040 TAX RETURN AND INCOME FOR ALL
INDIVIDUALS NOT DECLARED AS 1040 DEPENDANTS

PROOF OF INCOME FOR THE HOUSEHOLD
REQUIRED WHEN AN INCOME TAX RETURN HAS BEEN FILED

1. **IRS 1040 INCOME TAX FORM** and
2. **IRS FORM 4506T**

REQUIRED WHEN AN INCOME TAX RETURN HAS NOT BEEN FILED

1. **IRS FORM 4506T**
2. **ONE OF THE FOLLOWING ACCEPTABLE PROOFS OF INCOME:**
 - a. **COPY OF MOST CURRENT W-2** to compare to 4506T, or if no taxes filed use Box 1. as gross income
 - b. **COPY OF PAY STUBS** for all incomes for 1 month (a minimum of 2 stubs if paid monthly)
 - c. **SELF-EMPLOYED INDIVIDUALS** must provide accounting of income or quarterly tax payments.
 - d. **SOCIAL SECURITY** will **NOT** be counted as household income for purposes of determining slide eligibility and category.
 - e. **TWO LETTERS** from non-family verifying that the patient has no income. The letter should include printed name, signature and date. (See common drive for template; common drive/Slide Forms-Current/Slide Unemployment Form)

(Please make us aware of any changes that would affect your slide category)

**WE CANNOT DISCOUNT YOUR SERVICES
UNTIL THE APPLICATION AND
VERIFICATION OF INCOME IS COMPLETED.**

- Discounts will be applied **ONLY 30** days prior to the completion of the application.
- The slide information covers the current fiscal year (April thru March), and only individuals listed on the application are covered, if applicable.
- Slide category is based solely on the number of qualified individuals and income verification.

**YOUR COPAY IS DUE AT THE TIME OF SERVICE. FAILURE TO MAKE
YOUR COPAYMENTS WILL RESULT IN ADDITIONAL COLLECTION
EFFORTS.**

THIS PLAN IS DESIGNED TO HELP MAKE HEALTHCARE SERVICES MORE AFFORDABLE FOR YOU. WE APPRECIATE YOUR COOPERATION IN SECURING THE APPROPRIATE INFORMATION TO MAKE THIS PROGRAM AVAILABLE TO YOU AND YOUR FAMILY.

Northeast Missouri Health Council, Inc.
314 E McPherson St
PO Box 1027
Kirksville MO 63501
Phone: 660-627-5757

Fax: 660-627-6285 (Business Office)
Fax: 660-627-5802 (Administration)

FORM LETTER TO BE USED FOR PROOF OF UNEMPLOYMENT FOR SLIDING FEE SCALE

I HAVE KNOWN _____
Print the Full Name of the Applicant

FOR APPROXIMATELY _____
Period of Time you Have Been Acquainted with the Applicant

I AM VALIDATING TO MY KNOWLEDGE THIS PERSON IS NOT CURRENTLY EMPLOYED.

I AM NOT RELATED TO THIS APPLICANT NOR DO I RESIDE AT THE SAME RESIDENCE.

Please print full name of person verifying unemployment of applicant:

Signature of Person verifying unemployment of applicant:

Date Signed: _____

NORTHEAST MISSOURI HEALTH COUNCIL, INC.
SOLICITUD PARA DESCUENTOS DE TARIFAS MÓVILES

AR-1 B

Fecha de entrada en vigencia: 4/1/2008

Northeast Missouri Health Council, Inc. puede ofrecer servicios a un precio con descuento basado en el número de integrantes de su familia y en sus ingresos combinados. Si desea determinar la cantidad de descuento al cual puede acceder, se requiere la siguiente información. La información presentada debe ser exacta y completa dentro de lo posible y se mantendrá completamente confidencial.

El número total de solicitantes es _____

	APELLIDO	NOMBRE	INICIAL DEL SEGUNDO NOMBRE	FECHA DE NACIMIENTO	EDAD	NÚMERO DEL SEGURO SOCIAL	RELACIÓN CON EL SOLICITANTE
1							
2							
3							
4							
5							
6							
7							
8							
9							

El ingreso anual verificado es \$ _____

X	Documentos que comprueban el ingreso	Fecha de recepción en la clínica
	(1) Declaración de impuestos (Ingresos brutos ajustados IRS 1040 (línea 36), 1040A (línea 21), 1040EZ (línea 4)	
	(2) Formulario 4506-T del IRS lleno	
	Si el paciente no presentó una declaración de impuestos, entonces se debe proporcionar UNO de los siguientes documentos junto con el Formulario 4506-T del IRS lleno:	
	(1) Copia del formulario W-2 más reciente (use la cifra del "Recuadro 1" para el ingreso total del paciente	
	(2) Copia de comprobantes de pago (de todos los ingresos durante un mínimo de 1 mes)	
	(3) Los trabajadores independientes deben proporcionar algún informe de ingresos o pago de impuestos trimestrales	
	(4) Dos cartas de personas que no sean familiares que verifiquen que el paciente no tiene ingresos (Consulte Documento adjunto XXX)	

Se le proporcionará una tarjeta de tarifas móviles. Esta tarjeta tendrá vigencia hasta el término del año fiscal (3/31) o hasta que cambie su situación financiera o de vida. **DEBE PRESENTAR ESTA TARJETA Y PAGAR EL COPAGO CADA VEZ QUE VISITE LA CLÍNICA.** El descuento se aplicará en todas nuestras clínicas, pero no todos los servicios están cubiertos por el programa de tarifas móviles. Consulte antes de recibir los servicios si necesita información sobre los servicios cubiertos. Si tiene seguro, al firmar este formulario nos autoriza a cobrarle a su seguro por el monto total de los servicios prestados. La clínica tiene derecho a recuperar el monto total del seguro y aplicará la tarifa móvil sólo después de que se hayan recibido y enviado todos los pagos o denegaciones del seguro.

Si no se obtiene un comprobante de ingresos y no se llena la solicitud de tarifas móviles en un plazo de **30 días** del servicio, el paciente debe pagar el cargo total. Esta solicitud califica a las personas indicadas anteriormente para la categoría de tarifa móvil determinada para todo el año fiscal en curso a partir de la fecha en que se llena la solicitud. Nuestro año fiscal es del 1 de abril al 31 de marzo. Se debe llenar una nueva solicitud cada año.

He leído y comprendo la información anterior. Certifico que toda la información indicada es exacta, verdadera y completa. Si existe un cambio en el número de solicitantes o en mi situación financiera, me comunicaré inmediatamente con la clínica y volveré a presentar una solicitud de ser necesario.

Fecha

Firma del solicitante

Firma del solicitante conjunto

CATEGORÍA DE TARIFA MÓVIL _____

Llenado por: _____

Firma del personal de NMHC, Inc Fecha: _____

REQUISITOS PARA ESCALA DE TARIFAS MÓVILES

FORMULARIO DE SOLICITUD QUE IDENTIFICA LO SIGUIENTE

NOMBRES DE LOS SOLICITANTES

FECHA DE NACIMIENTO Y NÚMEROS DEL SEGURO SOCIAL E

INGRESO TOTAL FORMULARIO 1040 DE DECLARACIÓN DE IMPUESTOS E INGRESOS
PARA TODAS

LAS PERSONAS NO DECLARADAS COMO CARGAS FAMILIARES EN EL FORMULARIO 1040

COMPROBANTE DE INGRESO FAMILIAR

OBLIGATORIO CUANDO SE HA PRESENTADO UNA DECLARACIÓN DE IMPUESTOS

1. FORMULARIO DE DECLARACIÓN DE IMPUESTOS 1040 DEL IRS y

2. FORMULARIO 4506T DEL IRS

OBLIGATORIO CUANDO NO SE HA PRESENTADO UNA DECLARACIÓN DE IMPUESTOS

1. FORMULARIO 4506T DEL IRS

2. UNO DE LOS SIGUIENTES COMPROBANTES DE INGRESOS ACEPTABLES:

- a. **COPIA DEL FORMULARIO W-2 MÁS RECIENTE** para compararla con el 4506T o si no se presentaron declaraciones use el Recuadro 1 como ingreso bruto
- b. **COPIA DE COMPROBANTE DE PAGO** para todos los ingresos durante 1 mes (un mínimo de 2 comprobantes de pago mensual)
- c. **LOS TRABAJADORES INDEPENDIENTES** deben proporcionar un informe de ingresos o pago de impuestos trimestrales
- d. El **SEGURO SOCIAL NO** se contabilizará como ingreso familiar para propósito de determinar la idoneidad y categoría de tarifa móvil.
- e. **DOS CARTAS** de personas que no sean familiares que verifiquen que el paciente no tiene ingresos. La carta debe incluir el nombre en letra de imprenta, firma y fecha. (See common drive for template; common drive/Slide Forms-Current/Slide Unemployment Form)

(Infórmenos de cualquier cambio que afectaría su categoría de tarifa móvil)

**NO PODEMOS HACERLE DESCUENTOS EN SERVICIOS
HASTA QUE LA SOLICITUD Y
LA VERIFICACIÓN DE INGRESOS ESTÉ COMPLETA.**

- Los descuentos se aplicarán **SÓLO 30** días antes de completar la solicitud.
- La información móvil abarca el año fiscal en curso (abril a marzo) y sólo las personas indicadas en esta solicitud tienen cobertura, si corresponde.
- La categoría móvil se basa exclusivamente en el número de personas calificadas y en la verificación de ingresos.

**EL COPAGO SE DEBE CANCELAR AL MOMENTO DEL SERVICIO. DE
LO CONTRARIO SE REALIZARÁN OPERACIONES DE COBRANZA.**

ESTE PLAN ESTÁ DISEÑADO PARA AYUDAR A QUE LOS SERVICIOS DE ATENCIÓN DE SALUD SEAN MÁS ASEQUIBLES PARA USTED. AGRADECEMOS SU COOPERACIÓN PARA OBTENER LA INFORMACIÓN CORRESPONDIENTE A FIN DE QUE USTED Y SU FAMILIA PUEDAN ACCEDER A ESTE PROGRAMA.