Reduced Fee Application

Thank you for your interest in the Reduced Fee Program offered by Johnson Health Center. We are looking for ways every day to serve those in our area who are uninsured and underinsured. The purpose of this application is to help anyone interested in receiving health care at a reduced rate. There are several programs available to you: medical care, dental care, prenatal care, as well as prescription assistance.

There are documents that you will need to supply with your application and they are detailed on page 3 of this application. The application must be filled out **completely** before being turned in and it must also have **all** income requested. If the application is not completed it will not be processed. If you have any questions about how to fill out a section of the application, please ask the front desk.

Please select the service(s) for which you are applying (choose all that apply to patient):

□Adult □Pediatric □OB/Prenatal/Gyn □Dental □Behavioral Health

Demographics

Social security #: ______________ D.O.B. ______________ Email: ______________

(Name) First: ______________ M.I. ______________ Last: ______________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

(Phones) Home: ______________ Cell: ______________ Work: ______________

Employment Status: Full-Time Part-Time Self-Employed Non-Employed Retired Active Military

Are you currently a student? Yes No Are you a veteran? Yes No

Insurance (circle): Medicaid Medicare/Medicaid QMB Private Insurance I do not have insurance I do not have prescription coverage

Members of the Household

You must list ALL members of the household, including yourself. This includes age, relationship to applicant, type of insurance, and ALL sources of income. (Wages, child support, disability, social security, SNAP, etc.)

Name	Age	Relationship	Income	Type of Insurance

Household Income

Place of Employment: ____________________

If you are unemployed, how long? ____________________

How many hours per week do you work on average? ____________________

What is your rate of pay? ____________________

Pay period: ☐ Bi Weekly ☐ Twice Monthly ☐ Monthly ☐ Weekly

Does anyone in the household receive Disability, Social Security, or Pension income? (Please circle): Yes No
If there is more than one person receiving any of these benefits, please specify ____________________

Amount:
Disability____________________ Social Security ____________________ Pension ____________________

Monthly Expenses

List rent or mortgage, phone, utilities, car payments, cable, cell phone, prescriptions, loans, etc…

Expense	Monthly Amount	Expense	Monthly Amount

Important Information:

Please note that the Reduced Fee does not cover any lab work that we cannot perform in-house. You **will** receive a bill from those outside agencies that we have to send lab work to. If a referral to a specialty office is made for you outside of JHC, you will be responsible any charges incurred.

Medication Assistance Program (MAP)

The Medication Assistance Program (MAP) is specifically designed to help those who are currently without prescription coverage and who need assistance with their maintenance medications. Johnson Health Center staff coordinates with pharmaceutical companies to access medicine on your behalf. There is a fee of $5.00 for every medicine received and this can be paid by cash, check or credit card.

An application is needed for each medication. It can take 4 to 6 weeks to start receiving your medications. If you have questions about the MAP, please contact the MAP Coordinator at (434) 947-5967 ext. 1243, or ask to speak to Kelly McConnell after your appointment with your provider.

Checklist

In order to complete applications you will need to turn in ALL documentation of income. All documentation needs to be from the current year. This may include any items that pertain to you on this list:

- ☐ Last month's pay stubs (must be consecutive and a full month)
- ☐ Current year tax return, 1040 or schedule C if self-employed
- ☐ 1406T if you do not file taxes
- ☐ Child support documentation
- ☐ Unemployment award letter
- ☐ Pension or retirement award letter
- ☐ TANF award letter
- ☐ SNAP award letter
- ☐ General relief award letter
- ☐ Letter of support

Please speak with your provider or contact Kelly McConnell at (434) 947-5967 ext. 1243 for more MAP information.

Frequently Asked Questions

How long does it take to process the application?

Your application can be approved when you come in as long as the application is complete. The applications take approximately 24 to 48 hours to process if you leave it at the front desk.

What if I am unemployed, how do I show income?

If you are currently unemployed, JHC will need a letter of support. This is a letter from whomever you are staying with stating that you are staying at their residence. *If you are reporting zero income for an application, you may only be approved for six months. After which you will need to supply proof of household income for ALL those in the household (household is defined as patient, patient's spouse/partner, and any dependent children living in the home.*

What if I am only receiving income from Food Stamps, TANF, or General Relief?

Each time you sign up for a program like these, you are given an award letter for the year detailing the amount you will receive. You will need to provide this with your application. If you are receiving only food stamps, JHC will also need a letter of support to verify.

What if I did not file taxes last year?

If you did not file taxes, you must either call 1-800-829-3676 OR fill and mail the 4506-T form attached to this application to request a non-filer disclaimer from the IRS. This form is needed to process medication requests, without it, we cannot order your medications.

What if I am self-employed, can I still qualify?

Yes, if you are self employed all you need to have is the previous year's 1040 federal tax return along with the Schedule C tax forms. You can find these forms in your previous year's tax files.

Dental Services Frequently Asked Questions

If I receive assistance with JRDC or BDC, what does the Reduced Fee cover?

The reduced fee covers any service provided at JRDC or BDC. If you need specialty dental services (such as oral surgery), we will try to help find the service at a reduced rate, but cannot guarantee another provider's fee schedule.

If I have Medicaid or Medicare, can I still come to JRDC or BDC?

You can still come to our dental clinic if you are enrolled in Medicaid and Medicare. However, if you are over the age of 21 you will need to fill out the reduced fee paperwork completely and then you can be seen at the reduced rate.

Release of Information

I, the undersigned, attest to the accuracy and truth of the information provided within this application for services. Johnson Health Center staff may verify all information provided.

I authorize the release of information to Johnson Health Center Medication Assistance Program and the sharing of information about my application to other agencies, pharmaceutical companies, and physicians.

I authorize the staff of Johnson Health Center to sign on my behalf those documents required to access my prescription medication.

I understand that any changes in income and household must be reported to the Reduced Fee Coordinator as soon as possible. I will also report changes in address and phone number.

I understand that it is my responsibility to provide documentation and update my application every year or otherwise, if deemed necessary, in order to remain an active patient at Johnson Health Center and its participating agencies.

I, the undersigned, verify that the information provided as part of the Johnson Health Center Sliding Fee Application is true and accurate. If the information is determined to be false and misleading, I understand that the Johnson Health Center has the right to discontinue my sliding fee rate and I will pay the full fee.

This release expires in one year.

Printed Name: ____

Signature: ____

Date: ____

This Page for Office Use Only

Family Size: ______________________ Income: ____________________

After examination of this applicant's family size, situation, and financial information, it is my decision that this application is:

- ☐ Approved at the rate of:
  - ☐ A ☐ B ☐ C ☐ D
- ☐ Approved for OB Prenatal with a total cost of ____________________

- ☐ For children under age 18; ineligible for Medicaid:
- ☐ Does not meet citizenship or immigration status requirements
- ☐ Other: ____

- ☐ Denied, Reason: ____

For the Following Program(s):

☐ Adult Medical Services
☐ Pediatric Medical Services
☐ OB/Prenatal/Gyn Services
☐ Dental Services
☐ Behavioral Health Services
☐ Medication Assistance Program (MAP)

This status shall remain in effect for ___________ from this date, _____________ unless otherwise noted, at which time the applicant's financial situation will be reviewed to evaluate eligibility and classification.

Comments:

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____
____
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_______________________________________ ____________________________

Reduced Fee Coordinator Date