Reduced Fee Application Form

Patient name: ______________________________ DOB:______________

As a Federally Qualified Health Center, Johnson Health Center does not discriminate based upon a patient's ability to pay. JHC offers all patients the opportunity to apply for the Reduced Fee program.

Reduced Fee eligibility is determined using family size, household income, and the Federal Poverty Guidelines as updated annually by the Department of Health and Human Services. Federal Poverty Levels are determined annually as part of the Federal Poverty Guidelines.

Members of the Household

You must list ALL members of your tax 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?

☐ Yes ☐ No

Disability: $ ______________ Social Security: $ ______________Pension: $ ____________

If more than one person is receiving any of these benefits, please specify: ______________

Medication Assistance Program (MAP)

MAP is designed to help those who are currently uninsured or underinsured obtain eligible medications from pharmaceutical companies at an affordable price. JHC 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. Your signature is required to process the application with the appropriate pharmaceutical company. It can take up to 4 to 6 weeks to start receiving your medications.

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, but is not limited to, 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 form or schedule C if self-employed
- 4506T if you do not file taxes
- Child support documentation
- Unemployment award letter
- Pension or retirement award letter
- TANF award letter
- Food stamps award letter
- General relief award letter
- Letter of support

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

Reduced Fee 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 understand that any changes in income and household must be reported 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.

____ ________________________

Patient Signature *(parent/legal guardian if minor)* 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:

☐ Nominal ☐ Level B ☐ Level C ☐ Level D

☐ Approved for OB Prenatal with a total cost of ________________________________

☐ Approved for children under age 18 ineligible for Medicaid

☐ 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 from ________________ to ________________ unless otherwise noted, at which time the applicant's financial situation will be reviewed to evaluate eligibility and classification.

Comments:

____

____

____

____

____ ____________________

Reduced Fee Coordinator Date