Upham's Corner Health Center - Sliding Fee Discount Application

It is the policy of Upham's Corner Health Center (UCHC) that patients will not be denied needed health care services because of their inability to pay. Fees/charges for needed services will be discounted for eligible patients based on their family size and income. **Please complete the information below in order for a UCHC staff person to determine if you or members of your family are eligible for a discount.**

[*The discount will apply to all services received at Upham's Corner Health Center, but will not apply to those services or equipment that are purchased from outside, including drugs, eye glasses, dentures, dental laboratory services, reference laboratory testing, and radiology (x-ray and mammogram)*.]

Patient Information	**Today's Date:**		
First Name:	Middle Name:	Last Name:	
Street:	City:	State:	Zip:
Date of Birth:	Phone Number:		
Do you have insurance? ☐ Yes* ☐ No *Did you apply for MassHealth? ☐ Yes ☐ No *Insurance Notes:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		

Family Size: ***Either an individual (with a family size of "1"); or a group of two people or more (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.***

LIST BELOW: <u>Self</u> and any <u>Spouse</u> and/or <u>Dependents under age 18</u>

NAME	AGE	DATE OF BIRTH
Self/Applicant:		
Spouse/Partner:		
Dependent:		
Dependent:		
Dependent:		
Dependent:		

Income: ***Earnings over a given period of time used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.***

LIST BELOW: All income sources for applicant and spouse (proof/documentation for each should be provided)

NAME	MONTHLY AMOUNT	INCOME SOURCE (ex: job; disability; unemployment; etc.)
	$	
	$	
	$	
TOTAL INCOME	**$**	

Patient/Applicant Acknowledgement and Agreement

This is to certify the information I have given, regarding my present family size and income is true and accurate, to the best of my knowledge. I understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.

Print Name (Patient/Applicant) _____ Signature _____