Kentucky River Foothills Development Council, Inc.

Foothills Health and Wellness Center
108 12th Street
Clay City, KY 40312

Confidential Financial Statement/Sliding Fee Scale Application

Today's Date: ____________________________________

Patient Name: ______________________________ Date of Birth: ________________________

Address: ____ Phone: _____________________

Please complete the following statements as accurately and completely as possible. Foothills Health & Wellness Center reserves the right to withdraw discounts for failure to provide correct information. It is your responsibility to inform us immediately of any change in income and/or insurance status or household size.

Foothills Health & Wellness Center is required by the Bureau of Primary Healthcare to obtain proof of income from patients annually. We use the proof of income, along with the information gathered on this form, to determine the amount we can discount the fees charged to you and your family. **WE CANNOT PROVIDE A DISCOUNT WITHOUT THIS INFORMATION**. **Today's visit will be discounted based on the information provided below. If you do not have documentation for today's visit, you will be considered self-pay until verification of your income and residence is received [must be received by 60 days] and responsible for the cost of all services provided. (Initial)__________.**

The information contained on this form is protected under HIPAA legislation. It will be used only for the purposes of determining the level of discount provided and to enroll you in prescription patient assistance programs as needed. Your signature at the conclusion of this form indicates your consent for the sharing of this information with necessary pharmaceutical companies.

Please list all members residing in your household (including yourself):

Name **Date of Birth**

1.____
2.____
3.____
4.____
5. ____
6. ____
7. ____
8. ____

Do you have any health insurance? ________Yes ______No

Do you have a prescription card? _______ Yes ______No

Foothills Health & Wellness Center
A program of Kentucky River Foothills Development Council, Inc.

An Equal Opportunity Employer M/F/D

Kentucky River Foothills Development Council, Inc.

How many members in the household work? _________

Does anyone in the household receive money from the following?:

Wages from Employment	_____Yes	_____ No	Retirement	_____Yes	_____No
Self-Employment Wages	_____Yes	_____No	Black Lung	_____Yes	_____No
Social Security Checks	_____Yes	_____No	Alimony	_____Yes	_____No
Disability Checks	_____Yes	_____No	Child Support	_____Yes	_____No
Farming Income	_____Yes	_____No	Military Wages	_____Yes	_____No
SSI	_____Yes	_____No	Unemployment	_____Yes	_____No
VA Pension	_____Yes	_____No	Rental Property	_____Yes	_____No
Interest Income	_____Yes	_____No	Worker's Comp.	_____Yes	_____No

If your household has no income, who pays your monthly bills? _________________________________

In order to receive the Sliding Fee Discount at Foothills Health & Wellness Center, you must return the Foothills Health Sliding Fee Authorization form. This form will also be used to determine eligibility for prescription assistance programs. (Initial) _______.

____

Signature and Date of Interviewer

******FOR CLINIC USE ONLY (TO BE COMPLETED BY THE INTERVIEWER)********

Income Source	HH member	Amount				Yearly Income
_______________	_________________	______________	x	_________	=	______________
_______________	_________________	______________	x	_________	=	______________
_______________	_________________	______________	x	_________	=	______________
_______________	_________________	______________	x	_________	=	______________
_______________	_________________	______________	x	_________	=	______________

TOTAL YEARLY INCOME ______________

SLIDING FEE LEVEL APPROVED: ______________ EXPIRATION DATE: ________________

INTERVIEWER SIGNATURE: _________________________________ DATE: ____________________________

Foothills Health & Wellness Center

A program of Kentucky River Foothills Development Council, Inc.

An Equal Opportunity Employer M/F/D