Patient Label or ID #

ACCESS carroll
INTEGRATED HEALTH CARE
10 Distillery Drive • Suite 200 • Westminster, MD 21157

Sliding Fee Discount Application

It is the policy of Access Carroll to provide essential health services regardless of the patient's ability to pay at the time of service. Access Carroll offers discounts based on family size and annual income. The discount will apply to all services received at this facility by Access Carroll, but not those services or equipment purchased from outside entities, including reference laboratory testing, medications, radiology services, and specialty care services. You must complete this form every 12 months or if your financial situation changes. Please complete the following information to determine discounted service eligibility.

Date of Application: _____ Patient Full Name Printed: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Other: _____

Proof of household income is required to verify discounts. (See proof of income documents list.) Only first visits will receive a discount based on verbal claims or partial information. All following appointments will be charged at full rate until discount eligibility is verified with proof of income documents.

Please list all household members, including those under age 18, with annual or monthly income (specify).
Use back of form as needed for additional information.

Full Name	Relationship to Applicant	Birthdate	Monthly/Annual Income/Source	Staff Financial Verification
	SELF			

I certify that the family size and income information shown above is correct.

Patient/Guardian Printed Name: _____ Signature: _____

THIS SECTION COMPLETED BY STAFF ***STAFF NAME:*** _____

Eligibility Documents verified: ☐ Yes ☐ No **Estimated Federal Poverty Level:** _____**%**

Discount Level: ☐ Level A ☐ Level B ☐ Level C ☐ Level D ☐ Full Fee

☐ Patient instructed to bring in any required eligibility documents at next appointment or 100% full fees will be charged. Notes: _____

Date Approved: _____ Re-determination Date: _____

The Financial Counselor has explained to me my financial responsibility. I understand I must provide necessary documentation to continue to receive discounted services at Access Carroll. **Annual renewal eligibility is required.**

Patient/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____