Excellent Healthcare PRP and Services

4002 W. Belvedere Ave, Baltimore, MD 21215 PH:410-304-6544

FINANCIAL DISCOUNT APPLICATION

DUE DATE: _____

Excellent Healthcare and PRP Services is a community based organization that offers evidence and community based interventions to individuals and families. All patients may apply for a sliding scale discount based on their household size and income, with payment arrangements easily made. ***No one*** is turned away due to lack of funds. For those patients with Medical Assistance, Medicaid, Medicare and CHIP, we will bill directly as a courtesy of our patients. All patients will receive a monthly statement if there is a balance owed on their account. All balances are due within 30 days of the statement date. If you are unable to pay your balance in full, please call the front office staff to make payment arrangements at 410-304-6544.

***By completing this application, the information included will be used to determine if you qualify for a discount for service provided by EHPS Outpatient Mental Health Clinic. Information on this form may be requested and will be provided to Excellent Healthcare and PRP Services Quality Assurance department for audit purposes.

- Please complete this entire form if you are applying for a sliding fee scale discount.
- You have **10 business days to complete and return this packet in order to receive a discount** for your first visit. Otherwise your discount will begin on the date the packet is returned.
- We will not back date discounts.
- Discounts will only be given to those clients who qualify and provide verification.
- Once your application has been reviewed by our billing department, you will receive a letter in the mail notifying you of the discount that you are eligible for.
- All discounts will be valid for 6months at which time you will be asked to provide current verification.
- Discounts are only applied to medically necessary services/procedures
- You must notify the agency of any changes in your financial or living circumstances.

REQUIRED DOCUMENTS:

- Copies of the last 3 months of pay stubs
- A copy of unemployment verification, if you are receiving unemployment
- A copy of your most recent federal tax return
- Copies of other documents to verify income, such as letters from Social Security or disability services
- Copies of food stamps verifications, if you receive food stamps
- If you have no income, a letter that explains your means of living or a completed Attestation Form (available on request)

Patient Name: _____ **Date of Birth:** _____
(The following should be completed with information regarding the person responsible for the account.

Name of Responsible Party: _____ Relation to Patient: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____
Date of Birth: ___

**********For Office Use Only **********

Application Date: _____ **Expiration Date:** _____

Based on the information provided in this application, the above listed patients is eligible for a sliding scale discount of _____% with a $_____co-pay.

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Based on the information provided, the patient is <u>not</u> eligible for a discount at this time.

Information verified by: Paystubs Tax Return Other_____

Staff member completing form: _____Date: _____

*__**Please complete the following information for all household members:**__

	Name	Age	Relation to Patient	Monthly Net Income	Source of Income
1.					
2.					
3.					
4.					

Please complete the following information:
Are you currently employed? Yes or No
Is your spouse currently employed? Yes or No

If your household income is zero, please initial her _____and give a brief explanation of your current financial situation and living situation:

_____

_____

	Patient	**Spouse**
Net Monthly salary/wages (after taxes)	$_____	$_____
Income from any of the following sources:		
Child Support	$_____	$_____
Pension	$_____	$_____
Retirement	$_____	$_____
Worker's Compensation	$_____	$_____
Disability	$_____	$_____
Social Security	$_____	$_____
Unemployment	$_____	$_____
Rental Income	$_____	$_____
Total Net Monthly Income	$_____	$_____
Total Amount in Checking Account:	$_____	$_____
Total Amount in Saving Accounts:	$_____	$_____
Total number of people living in household	_____	

I hereby authorize representative of EHPS Outpatient Mental Health Clinic to make whatever inquiries necessary to verify the information furnished on this form, or to release any information regarding my office visits to any insurance company or third party to seek settlement of this account. I hereby state that to the best of my knowledge the information given above is true and complete. I understand that if any information is found to be incorrect, I may not be eligible for any future consideration of reduced rates and that any sliding fee taken in the past may be reversed and all accounts adjusted accordingly.

Patient/Responsible Party Signature: _____Date:_____