A Plus Family HealthCare
Discount Eligibility Application
ALL INFORMATION IS CONFIDENTIAL

Why do we need to know your household income?

- Some of our funding may come from grant money. For most of these grants, income information from our patients is necessary to prove financial need in the communities we serve.
- These grants allow us to provide a much higher level and greater availability of care than we could otherwise afford
- In order to obtain these grants, and to keep them, we need to provide demographic information, including financial resources of patients, to prove that we are serving the people the grant money has been set aside for.

Definitions:

Household members:

All members of a household who are pooling financial resources in addition to room and board and/or are supporting one another financially are counted as one family.

Income:

Income is defined as cash receipts received from all sources before taxes, including:

- Wages and Salaries
- Receipts from self-employment less operating expenses
- Payments from public assistance, social security, strike benefits, military allotments, disability, child support, government or private pensions, regular insurance or annuity payments
- Income from dividends (including permanent fund & longevity dividends), interest, rents, royalties, estates or trusts

_____ I am **NOT interested** in disclosing my financial information; therefore I acknowledge my family and I are not eligible for the sliding fee discount program. (If you checked this box, please skip the following sections)

Eligibility Determination

Household members/ Household income:
List your name and the name(s) of ALL individuals who live with you.

Name:	**Relationship:**	**Age**	**Annual Income**

If you need more space, please continue on the back of this form.

TOTAL # IN HOUSEHOLD: _____ **TOTAL HOUSEHOLD INCOME:** _____

Household Address: _____

Do you or anyone living with you have Health Insurance, Medicare or Medicaid? Yes: _____ No: _____
If so, please provide a copy of the insurance card, Medicare Card, or State Medicaid to the receptionist.

Have you applied for KY State Medicaid: Yes: _____ NO:_____

This information must be updated each year, and anytime your income, household size and/or medical insurance status changes.

I understand that the information I provide on this form is subject to verification by APlus Family HealthCare. I certify that the above information is true and correct to the best of my knowledge.

_____ _____
Patient/Guardian Signature Printed Name Date

_____ _____
Signature of A Plus Representative Discount % to be applied: Date