

Mangum Regional Hospital & Family Clinic

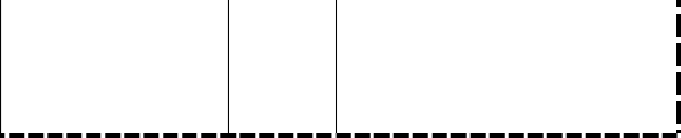
Sliding Fee Discount Application

# Sliding Fee Discount Information

It is the policy of Mangum Regional Hospital & Family Clinic to provide essential services regardless of the patient’s ability to pay. ABC offers discounts based on family size and annual income. Mangum Regional Hospital and Family Clinic does NOT require a “Medicaid Denial Letter” or any “Net-Worth Testing” to be eligible for the discounted fee.

Please complete the following information and return to the front desk of the hospital or clinic to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.



NAME

Street

City

STATE ZIP

Phone

Please see the next page to continue the application……

Please list all household members, including those under age 18.

|  |  |  |
| --- | --- | --- |
|  | **Name** | **Date of Birth** |
| **SELF** |  |  |
| **OTHER** |  |  |
| **OTHER** |  |  |
| **OTHER** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Source** | **Self** | **Other** | **Total** |
| **Gross wages, salaries, tips, etc.** |  |  |  |
| **Income from business and self- employment** |  |  |  |
| **Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or**  **retirement income** |  |  |  |
| **Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other**  **miscellaneous sources** |  |  |  |
| **TOTAL INCOME** |  |  |  |

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

**Name (Print)**

**Signature Date**

Office Use Only

Patient Name:

Approved discount:

Approved by:

Date Approved:

|  |  |  |
| --- | --- | --- |
| **Verification Checklist** | **Yes** | **No** |
| **Identification/Address: Driver’s license, utility bill, employment identification, or**  **other** |  |  |
| **Income: Prior year tax return, three most recent pay stubs, or other** |  |  |