



Application for Sliding Fee & Discounted Prescriptions

Upon approval, discounts will be applied to the services rendered at all Health Access Network Clinics.

Name: _____

SS# _____

Address: _____

Telephone# _____

DOB: _____

Total Number Living in the Home* _____ *ALL people living in the home are to be listed - **even if not related or not working**. Use reverse side of form if necessary.

<u>Name (First & Last)</u>	<u>Relationship</u>	<u>DOB</u>	<u>Monthly Income</u>	<u>Health Insurance?</u> (Mainecare,Aetna etc.)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

* Members listed will be cross-checked with our records. Applications with discrepancies will be returned for additional information.

List all **HOUSEHOLD** income and **ATTACH VERIFICATION** for **EVERY** person who lives in the home**. **Attach your most recent years' tax return as income verification.** If you were not required to file a tax return for the previous year, other acceptable forms of income verification include: at least 3 months worth of pay check stubs, Social Security/Pension or other benefit letter, interest statements, copies of check stubs for child support/alimony/foster care and/or adoption subsidy, divorce/custody decrees stating payments to be made or bank statements showing direct deposits.

** Applications for discounted services will be returned if all proof of income is not attached.

	<u>Total last 1 month</u>	<u>Total last 3 months</u>
Wages (Gross)	_____	_____
Self Employment	_____	_____
Social Security/SSDI	_____	_____
Workers Comp	_____	_____
Unemployment	_____	_____
Alimony/Child Support	_____	_____
Pensions	_____	_____
Dividends/Interest	_____	_____
Other	_____	_____
TOTALS	\$ _____	\$ _____

I request that Health Access Network (HAN) make a determination of my eligibility for the sliding scale for services rendered by any HAN medical facility. I understand that the information I submit is subject to verification by HAN. I also understand that if the information which I submit is determined to be false, such a determination will result in denial of the sliding scale eligibility, and I will be liable for payment in full.

I affirm that the above and attached information is true and correct to the best of my knowledge. If I become eligible for the sliding scale and do not make the required payments, I am aware that my account, and/or the accounts of my eligible family members listed above, will be sent to a collection agency.

APPLICANT SIGNATURE: _____

DATE: _____

Updated 8/06