NORTHWEST HEALTH SERVICES

| TODAY'S DATE: |
|---|
| |

| Applicant Name: |
|---|
| Guarantor # *(office use only)* |
| Address: |
| City, State, Zip: |
| County: |
| Date of Birth: |

**HOUSEHOLD MEMBERS:**

Household members must actually live in your household, regardless of marital status, and you must be financially responsible for them. I am financially responsible for (#)_____ household members (include yourself).

**(All household member's names and date of birth must be listed on the next page)**

**DISCOUNT PROGRAM APPLICATION**

It is necessary to ask you for personal financial information in order to give you a discount on your medical services. This information will be held in our office in strict confidence. Discount Program applications expire on **April 30** of each calendar year. At that time, we will ask you to again verify your current income and number of household members in order to receive discounts on your medical services.

**HOUSEHOLD INCOME:**

Household income includes ALL income generated by the household, regardless of marital status. Income may include but is not limited to the following:

- ☐ Alimony
- ☐ Child Support
- ☐ Disability
- ☐ Interest Income
- ☐ Pensions
- ☐ Salaries
- ☐ Self Employment Records
- ☐ Social Security
- ☐ Unemployment
- ☐ Student Pell Grants

Please check all of the above that apply to your household income and provide proof of all income circled above.

My yearly household income is:

$_____.

I understand:

- If I have insurance I must show a copy of my current insurance card at each visit and my insurance must be filed and processed/paid before I receive any benefits from the Discount Program.
- If I receive insurance payments I must bring the payment to the office to be applied to my visit before my discount will be given.
- Services not eligible for discount are:
  - Motor Vehicle Accidents
  - Workers Comp
  - Elective procedures and hospital procedures
  - Services received from providers outside of Northwest Health Services.

## HOUSEHOLD MEMBERS:

| | Name | Relationship | Date of Birth |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |

- I have read and understand the information contained in "The Discount Program Details" and agree to abide by these guidelines.
- I understand my information will be kept in strict confidence and that if my income changes I am required to notify NHS on my next visit to the clinic.
- I declare the information I have given is true and give Northwest Health Services (NHS) consent to investigate any information given in this application.
- Based on the number of people in my household and the income information I provided, I understand my copay for each medical visit is $_____ and this copay must be paid at the time of service.
- I further understand that copays for dental services vary, based on procedure, and the amount due from me will be discussed with me prior to services being rendered.

| | | |
|---|---|---|
| **Applicant Signature:** | Date: | |
| (FOR OFFICE USE ONLY)<br>**PAA Signature:** | Date: | INCOME LEVEL |
| **Discount Program Specialist Verification/Signature:** | Date: | INCOME LEVEL |