

TODAY'S DATE:

Applicant Name:

Address:

City, State, Zip:

County:

Date of Birth:

DISCOUNT PROGRAM APPLICATION:

It is necessary to ask you for personal financial information in order to give you a discount on your healthcare services provided by Northwest Health Services. This information will be held in our office in strict confidence. Discount Program applications expire one year from the date you apply. 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 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 next page.

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:

Salaries Alimony Social Security

Student Pell Grants Interest Income

Pensions Child Support Disability

Self Employment Records Unemployment

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 cosmetic procedures and hospital procedures
 - Services received from providers outside 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) PAA Signature:	Date: INCOME LEVEL