

AcadianaCares

809 Martin Luther King Jr. Dr. Lafayette, LA 70501 Phone (337)704-0787 Fax (337)233-7179

Application for Reduced Fee Status

Applicant's Name	Social Security #	Date of Birth
Spouse's Name	Social Security #	Date of Birth
Mailing Address	Email Address	
City, State, Zip	Phone#	
Employer Name/Address/Phone	Spouse Employer Name/Address/Phone	
Additional Members of Household		
Name/Relation/Date of Birth	Name/Relation/Date of Birth	
Name/Relation/Date of Birth	Name/Relation/Date of Birth	
Name/Relation/Date of Birth	Name/Relation/Date of Birth	
		Total # in Household

Family Income Determination Worksheet (please indicate amount and frequency of pay)

Wages	Disability Income	Welfare Payments	Veteran's Benefits
Business Income	Unemployment Benefits	Aid to Dependent Child	Checking/Savings Account*
Farm/Seasonal Income	Social Security Benefits	Alimony	Other (please specify)
Food Stamps	Pensions/Annuities	Child Support	Total Annual Gross Income

*Provide copy of **MOST RECENT** bank statement



Office Use Only

Applicant	Date Rec'd
Acct(s)	Site
	BC
	FS
Reduced Fee Status	AGI
	Expiration Date
Authorized Signature	

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The following items are required before the application can be processed.

Proof of Income

Proof of household income includes the following:

1. A copy of the previous year's tax return or W-2 forms.
2. Check stubs from your current job or a letter from your employer stating gross earnings.
3. Proof of social security income, food stamps, or other public assistance.
4. Proof of child or spousal support.
5. **Copy of most recent bank statement (required). If no bank account, please indicate NONE.**

Proof Of No Income

If you currently have no household income, please include one of the following:

1. Statement from Louisiana Workforce Commission approving or denying unemployment compensation.
2. Termination notice from previous employer.
3. Layoff notice from previous employer.
4. Statement from person supplying food and shelter.
5. Proof of Medicaid or welfare cancellation.
6. If there is no income at the time of financial eligibility screening, the family will be designated as Slide Fee A, and financial screening will be reviewed in ninety (90) days. Explain below in "Remarks" how family is supported financially, e.g. savings, loans, etc.

Other Income

Unusual situations not previously described should be fully explained in the section below.

Remarks



AcadianaCares
A NETWORK FOR HEALTHY LIVING

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Statement of Understanding

The information I have provided concerning the size of my family and my family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge.

I have given this information concerning my financial situation and my means and ability to pay, for purpose of procuring for my own and my family's benefit, the discount of my accounts with AcadianaCares Community Health & Wellness Center (Cares). I understand that Cares will rely on such information to determine an applicable discount rate for my account.

I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the State of Louisiana.

I agree to report any change in either my income or my family size to Cares before or at the time of my next contact or any contact by any family member with Cares. I know that the information I have given will continue to be relied upon until it is changed.

I understand that my discount status will be reviewed on an annual basis and adjusted according to my family income and size at the time of review. If Cares has reason to suspect that the information I have given is untrue, inaccurate, or that I have not properly reported changes, Cares may initiate a review of my status. I hereby authorize the investigation of all statements contained herein and authorize the release of all employment records, bank record, and other financial information to an agent of AcadianaCares Community Health & Wellness Center.

My signature below indicates that all information I have provided is true to the best of my knowledge.

Applicant Signature

Date

Spouse Signature

Date



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