Fee Discount Application

AcadianaCares shall provide services at an affordable price. No person shall be denied service due to inability to pay.

If you feel you qualify for a fee discount, please complete the following form and bring it to an AcadianaCares employee for processing. This can be done during your next visit.

Discounts are based on each person's income, the number of people living in each person's household, and services being provided. In order to process a fee discount application, you **must** provide the following:

- Photo identification
- Proof of income, such as a current/recent paycheck stub, bank account statement, social security payment, unemployment payment, public assistance, alimony, or child support.
- Net receipts if self-employed.
- Proof of other family living in the household, such as birth certificates, social security cards, marriage license, or tax forms showing family relationship.
- Existing insurance information, such as a current insurance card.

Applications may not be processed if information is not provided to AcadianaCares. Applications that are accepted shall only be applied to future billing.

An AcadianaCares employee can explain the discount (sliding) fee scale to you in more detail when you submit your application.

08.11.01 Application for Reduced Fees

AcadianaCares intends to provide health care and wellness services to clients and patients at an affordable price. In order to do this, AcadianaCares must know and document how much money you earn to provide services at appropriate reduced fees, according to the agency's sliding fee scale. Your information also may help AcadianaCares determine if you are eligible for other financial assistance programs. If you have questions about this application, please contact AcadianaCares at 337-233-2437, ext. 176.

Applicant First/Last Name	Social Security #	Date of Birth
Spouse First/Last Name	Social Security #	Date of Birth
Mailing Address	Email Address	
City, State, Zip Code	Phone #	

Employer Name, Address, Phone	Spouse Employer Name, Address, Phone

Family Income: Indicate amount and frequency of pay ($ per week, month, or year). Please provide a copy of your most recent proof of income statement or payment.

Wages	Disability Income	Welfare Payments	Veteran's Benefits
Business Income	Unemployment	Aid to Dependents	Checking/Savings
Farm/Seasonal Income	Social Security Benefits	Alimony	Other (describe)
Food Stamps	Pensions/Annuities	Child Support	Total Gross Income/Year

Additional Household Member Information

First/Last Name, Relation, Date of Birth	First/Last Name, Relation, Date of Birth
First/Last Name, Relation, Date of Birth	First/Last Name, Relation, Date of Birth
First/Last Name, Relation, Date of Birth	First/Last Name, Relation, Date of Birth

FOR OFFICE USE ONLY:

Date Received:________________ Status:____________________ Initials:______

Total # in Household

A copy of your proof of income, or proof you do not receive income, is required to process your application.

1. Proof of Income

Proof of household income includes:

1. A copy of the previous year's tax return or W-2 form.
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.

2. 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 a Slide Fee A and financial screening will be reviewed in 90 days. Describe on a separate page how your family is supported financially (i.e. savings, loans, etc.).

3. Other Income

Describe on a separate page any unusual situation not previously described.

Statement of Understanding

The information I provided concerning my family size and my family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge. I have given information concerning my financial situation and my ability to pay for the purpose of obtaining a financial discount for health care services provided to me or my family by the AcadianaCares Community Health and Wellness Center. I understand AcadianaCares will rely on such information to determine an applicable discount rate, if any, for my account. **I understand that knowingly providing false information may result in criminal prosecution.**

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

I understand 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 AcadianaCares has reason to suspect the information I provided is untrue, inaccurate, or outdated, AcadianaCares 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 records, and other financial information to an AcadianaCares agent.

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

______________________________ ______________________________

Applicant Signature/Date Spouse Signature/Date