GPW Health Center *Dedicated to Your Health!*

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Self-Declaration of Eligibility for Discount Fee Program

Self-declaration is available to all patients regardless of income level, insurance coverage, discount pay class, or population type.

PATIENT INFORMATION

_____ _____ _____ _____
First Name Middle Name Last Name DOB

Section 1

Self-declaration of Shared but Separate Households

Self-declaration of shared but separate households is valid for 12 months or until the application is renewed whichever is soonest.

I _____ declare that although more than one family occupies the same space, each household earns separate incomes / or means of support and do not share the same living space. I understand that Providing false information now, or that later is found to be false, is fraud. Which means all discounts will revoked and I will immediately pay for services received without any discount.

Section 2

Self-declaration- Source of income is cash and unable to provide required documentation

Self-declaration- Source of income is cash and unable to provide required documentation. This is valid for 12 months or until the application is renewed whichever is soonest.

I _____ declare that my approximate combined household income including benefits, assistance, earnings, all other cases not covered is $_____annually. I understand that Providing false information now, or that later is found to be false, is fraud. Which means all discounts will revoked and I will immediately pay for services received without any discount.

Section 3

Self-declaration of Income –Unable to provide required documentation on the day of appointment

Valid for one day **only and** may **NOT** be offered more than once in the 12-month period in which the discount fee application is valid.

I _____ declare that my approximate combined household size of _____ and income including benefits, assistance, earnings, all other cases not covered is $_____annually. I understand the Discount Fee Program and agree to comply with it. By signing this section, I understand that I am applying for the discount and authorize the center to confirm my family/household income and size. I verify that all information provided to determine if my family/household qualify for the Discount Fee Program is true and correct. I understand providing false information now or later found to be false, is fraud. Which means all discounts will revoked and I will immediately pay for services received without a discount.

BASED ON DISCOUNT GROUP: 1 2 3 4 ☐ NO DISCOUNT

_____ _____
Patient Signature (VOID IF BLANK) Date

Effective Date:
Approved Date:
Revision Date: