Shawnee Health Service

SHAWNEE'S FINANCIAL ASSISTANCE PROGRAM APPLICATION

Because we are a Community Health Center, we have the opportunity to offer a discount on your services based on your family size and adjusted gross income. This discount is available to all patients who are uninsured or under-insured. If you feel this may be a benefit to you and your family, please complete this Application and provide the following documentation.

REQUIRED:

☐ Proof of Identification

☐ Proof of Family Size
Application or if available verify using the Tax Return

☐ Proof of Family's Adjusted Gross Income (AGI)
Preferred Method is the most recent Tax Return

If unavailable or you have a different job then the job reported on the most recent taxes, then you can use the most recent paycheck stubs (for the last 30 days) from your current employer

If you receive social security benefits and taxes are not available a copy of the benefit letter must be obtained

The last resort is the SHS Income Attestation Form, however it must be for one of the approved reasons listed below

Only to be used if a most recent tax return or paycheck stubs are not available or appropriate:

☐ Attestation – Patients may complete an Attestation form to prove income if they meet one of the following criteria:

Unemployed family members financially supported by another family member or individual
Adults who work seasonally or intermittently
Adults paid in cash
Adults whose only source of income is social security benefits
Homeless, living in a shelter

Shawnee Health Service

SHAWNEE'S FINANCIAL ASSISTANCE PROGRAM APPLICATION

Are you applying for yourself or are you applying for yourself and other members of your family? Please mark the appropriate box

☐ **PATIENT ONLY** ☐ **PATIENT AND FAMILY MEMBERS**

Name: (First, Middle Initial, Last):	Date of Birth:
Address	City/State/Zip:
Other Names Used:	
# of people supported in the home:	Phone:

FAMILY MEMBERS WHO ARE INCLUDED IN YOUR HOUSEHOLD:

Your family is what you claim on your tax return. Complete the table below. Attach documents (birth certificate, divorce papers, marriage license, foster or guardianship paperwork) if there have been changes since the tax return. If you are pregnant, please add "unborn child" to this list.

Family Members	Relationship	Date of Birth	Employed	SIU student	Medical Insurance /Medicaid	Dental Insurance	√ if applying for family member
			Y/N	Y/N	Y/N	Y/N	
			Y/N	Y/N	Y/N	Y/N	
			Y/N	Y/N	Y/N	Y/N	
			Y/N	Y/N	Y/N	Y/N	
			Y/N	Y/N	Y/N	Y/N	

☐ **PATIENT DECLINED MEDICAID ASSISTANCE**

AGREEMENTS: By signing below, I agree that:

- I certify that the information I provided is true and correct to the best of my knowledge. I understand that if the information I provided is determined incorrect, the discount will be denied.
- I have completed and attached all required documentation.
- I understand that it may take two (2) business days to process my application.
- I agree to promptly inform Shawnee if there are changes to my income, household size or insurance coverage.
- I understand that certain services and/or items cannot be discounted.
- I agree to pay a nominal fee at the time of service.
- I understand that an auditor of any patient assistance program I may benefit from may review the information in this application.
- If receiving medication through the Pharmaceutical Assistance Program, I give permission for Shawnee to sign patient assistance applications for me to order my medication. This consent is valid as long as I am a patient of Shawnee Health Service, or until I revoke my permission in writing.

Applicant Signature: _____ Date: _____

Interpretation Provided By: _____