Policy

It is the policy of MedStop One to provide essential medical services regardless of the patient's ability to pay. Discounts are offered based upon family/household size and annual income. A sliding fee schedule is used to calculate the basic discount and is updated each year using the Federal Poverty Guidelines. Once approved, the discount will be honored for six months, after which the patient must reapply.

Discount Application Process

A completed application including required documentation of the home address, household income, and insurance coverage must be on file and approved by the business office before a discount will be granted. If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required. Adolescent patients seeking confidential care are exempt from the application process, and services are provided at the nominal rate.

Medical	The discount is applied to all in-office services and Off-site services supplied by MedStop One healthcare providers.
Pharmacy	Samples are provided, when available, without charge.

Services Covered and Excluded

MedStop One

Discounted/Sliding Fee Application

It is the policy of MedStop One to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family/household size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This form must be completed for each visit. Please inquire at the front desk if you have questions.

Number of related persons living in your household:

Household Member	**Household Income (complete one column)**		
	Annual	**Monthly**	**Bi-Weekly**
Self			
Spouse			
Dependent Children under age 18			
Total			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment, and public aid.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print):_____

Date:_____

Signature:_____

Office Use Only

Patient Name:_____

Discount:_____

Date of Service:_____ Approved by:_____

Family Assistance Plan Application

HEAD OF HOUSEHOLD:_____

PLACE OF EMPLOYMENT:_____

STREET:_____

CITY:_____ STATE:_____ ZIP:_____

SSN:_____ PHONE:_____

HEALTH INSURANCE PLAN:_____

PLEASE LIST SPOUSE AND DEPENDENTS UNDER AGE OF 18:

Name	Date of Birth
SELF	
SPOUSE	
DEPENDENT	
DEPENDENT	

ANNUAL HOUSEHOLD INCOME:

SOURCE	SELF	SOUSE	OTHER	TOTAL
GROSS WAGES, SALARIES, TIPS, ETC.				
SOCIAL SECURITY, PENSION, ANNUITY, AND VETERANS'S BENEFITS.				
ALIMONY, CHIILD SUPPORT, MILITARY FAMILY ALLOTMENTS.				
INCOME FROM BUSINESS SELF EMPLOYMENT, AND DEPENDENTS.				
RENT, INTEREST, DIVIDENT, AND OTHER INCOME.				
TOTAL INCOME:				

I CERTIFY THAT THE FAMILY SIZE AND INCOME INFORMATION SHOWN ABOVE IS CORRECT, COPIES OF TAX RETURNS, PAY STUBS, AND OTHER INFORMATION VERIFYING INCOME MAY BE REQUIRED BEFORE A DISCOUNT IS APPROVED.

NAME (PRINT):_____

NAME (SIGNATURE):_____ DATE:_____

OFFICE USE ONLY

PATIENT NAME:_____ DISCOUNT: _____

DATE OF SERVICE:_____ APPROVED BY:_____

VERIFICATION CHECK LIST:

Name	YES	NO	PENDING
ID/ADDRESS: DRIV LIC, BIRTH CERT, EMPL ID, SSN, OTHER:			
INCOME: PRIOR YEAR TAX RETURN, THREE MOST RECENT PAY STUBS, OR OTHER:			
INSURANCE: INSURANCE CARDS			
MEDICAID; APPLICATION MADE OR EVIDENCE OF REJECTION.			