Primary Care of Jamestown
A Subsidiary of Presley Healthcare

SLIDING FEE DISCOUNT PROGRAM APPLICATION

- *A separate application is required for each member of the household who wants to participate in this program, including minor children.*
- *You must complete the entire application.*
- *If you need assistance, please contact Patient Services by visiting our office location or calling 931-879-5864.*

Name: _____ Date of Birth: _____

Mailing Address: _____

Primary Phone Number: _____ Cell Number: _____

Do you have health insurance?: YES / NO If Yes, please list _____

Have you applied to Medicare/Medicaid within the last year? YES / NO
We recommend that all applicants apply to Medicare/Medicaid each year.

It is necessary for Primary Care of Jamestown, LLC to ask personal questions in order to determine if you are eligible for this program. This information will be kept on file in strict confidence. You must verify your income when you apply and once a year when your application is renewed. Copies of your yearly federal income tax return, payroll check stubs covering the past month, Social Security benefit statements or other income sources are required. We cannot use bank statements for this purpose. Your annual income and household size will be used to determine your visit fee. I declare the above information is true and give Primary Care of Jamestown, LLC permission to investigate any information in this application.

I understand that:

- My information will be held in strict confidence.
- If this information is found to be false, I will lose my eligibility for the program and be liable to repay any benefit I have received.
- If my income or household size changes, I am required to notify the Patient Services as soon as possible,
- I have six weeks to return this application complete with proof of my annual income or this application will expire.
- I may reapply to the program at any time, but reduced fees will apply only from the date of the new application.
- If I am found to be eligible for reduced fees but failed to make required payments, my account may be sent to a collection agency.

_____ _____
Patient Signature Date

_____ _____
Parent/ Legal Guardian Signature Date

931-879-5864 (Clinic)
931-879-0796 (Fax)
www.jamestownmedical.com

Clinic Address:
101 S Duncan St | Suite C
Jamestown, TN 38556

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SLIDING FEE DISCOUNT PROGRAM APPLICATION CHECKLIST

- Complete signed application for each applicant, listing all household members and income sources
- Proof of income for each income source for each adult
- If you have very low or no income, you must complete the "Zero Income Worksheet" for each adult to be considered for the program.
- Most recent federal tax return if you file taxes

HOUSEHOLD: Please list all names and date of births for all members of your household **including yourself.**

- If you file taxes your household is you, your spouse and any dependents you claimed on your taxes.
- If you are claimed as a dependent by someone else, your household is you, the person who claims you and anyone else listed on their tax return.
- If you do not file taxes and are not claimed as a dependent by anyone else, your household is you and your spouse and children if they live with you.

INCOME: You need to provide proof of income for each of the following sources of income for each member of your household to see if you qualify. Please note that we cannot accept bank statements as proof of income.

If you have very low or no income, you must complete the Zero Income Worksheet.

Employed: Pay stubs for the last four weeks OR federal tax return

Self-employment and Rental Income: you must provide a copy of your most recent federal tax return

Current Benefit Statement for:
Unemployment | Social Security | TANF | Worker's Compensation | Long or short term disability | Child support/Alimony | Retirement pension and or annuity

First and Last Name	Relation to you	Date of Birth	Gross Income before taxes and deductions	Income Source with documents attached
	SELF		$_____ per	
			$_____ per	
			$_____ per	
			$_____ per	
			$_____ per	

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Zero Income Worksheet

Application for (*person with NO income*): _____

Date of Birth: _____

I, _____ certify that I have not received any income since _____.

Place(s) of last

employment:_____.

_____ I am a full-time student over the age of 18.

Housing

I live in:

_____My own home/apartment Do you receive housing assistance? Yes No

_____Someone else's home/apartment Name of house/apartment owner:

_____

_____Shelter/Transitional housing

Other: _____

Food

Do you receive Food Stamps? _____Yes (If Yes, you must attach a copy from DHHS.)

_____No

Transportation

_____I have my own vehicle

_____A friend or relative provides me with transportation

_____I use public transportation

Communication Expenses

Do you have a cell phone? Yes No

If Yes, who pays for your cell phone? _____

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All person(s) that have provided you with assistance in the past 3 months (monetary or non-monetary), must complete the following charts and sign below verify what assistance they have provided for you.

- **If someone has given you money to pay for expenses below, indicate how much they have paid and write their name in the appropriate box.**
- **If someone has provided you any of the below expenses for free, please indicate free and put their name in the appropriate box.**

EXAMPLE ONLY	Month	May 2017
	$ or Free?	Who Assisted?
Housing Expenses	Free	Mom
Utilities (water/sewer/electric)	included	
Heat	included	
Food Expenses	$189	Food stamps
Transportation Expenses	$20	Grandma
Communication Expenses	$40	Mom
Medical Expenses	none	
Other Expenses	none	

(Mom & Grandma would then sign form + attach food stamp letter)

Month # 1	Month	
	$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Month # 2	Month	
	$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Month #3	Month	
	$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Printed Name and Signature of Person(s) who provided you with assistance:

_____ **Date:** _____

_____ **Date:** _____

*This form must be filled out completely; we will not.be able to process your application if you leave parts of it blank. If you need to tell us more about your specific situation, please feel free to attach a letter or statement to this worksheet. If you receive assistance from other agencies, (LiHeap, General Assistance etc.) please attach copies of any assistance provided to you.

I do hereby swear and attest that all the information above about me is true and correct.

Signature of *Person with No Income*: _____ **Date:** _____

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