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
- Tax Return
- Attestation

☐ Proof of Total Family's Modified Adjusted Gross Income
- Tax Return
  - -OR-
- 4 Consecutive Paystubs
- Paid in Cash – Attestation
- Social Security/Disability Benefits
- Pensions (1099 or letter showing the amount)
- Workers Compensation
- Job Reimbursement
- Child Support
- Alimony
- Life Insurance
- Trust Fund
- Railroad Benefits
- Veteran Benefits
- Retirement Benefits

OPTIONAL:

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

- Unemployed adults supported by another adult
- Adults who work seasonally or intermittently
- Adults paid in cash
- Adults whose only source of income is SSA/Disability benefits
- Homeless

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Name: (First, Middle Initial, Last):		Date of Birth:
Address	City/State/Zip:	Phone:
Other Name Used:		
Confidential Service: □ Yes □ No 12 years - 26 years of age	Confidential Phone:	# of people supported in the home:

FAMILY MEMBERS:
Your family is what you claim on your tax return. Complete the table below. Attach documents (birth certificate, divorce papers, marriage license) if there have been changes since the tax return. If you are pregnant, please add "unborn child" to this list. ***A copy of your tax return is required.*** If you do not file tax return, an **Attestation Form** is required - please ask for assistance.

Family Members	Relation	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	

AGREEMENTS: By signing below, I agree that:

- I certify that the information I provide is true and correct and that if the information proves to be incorrect, the discount will be denied.
- I have completed and attached all required documentation.
- I understand that it may take two business days to process my application.
- I agree to 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 services.
- I understand an auditor of any patient assistance program that I may benefit from may review the information.
- If receiving medication through the Pharmaceutical Assistance Program, I give permission to Shawnee Health Service and Development Corporation 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 and Development Corporation, or until I revoke my permission in writing.

Applicant Signature: _____ Date: _____

Interpretation Provided By: _____