Sliding Fee Schedule Application

MedLink Georgia centers are ***NOT "free clinics."*** We rely on patient payment to continue operations. However, you may qualify for a reduction in your payments if you meet prescribed income and household requirements. **IF YOU WISH TO APPLY FOR REDUCED FEES, YOU MUST COMPLETE THE INFORMATION BELOW, PROVIDE PROOF OF INCOME, AND SIGN THE CERTIFICATION STATEMENT.** Self-declaration (application is completed and discount is applied without proof of income) is allowed once per year and is valid for 30 days. Sliding Fee application and discount is valid for one year, however any change in family size or income will require a new application and updated proof of income.

INSTRUCTIONS:

- List everyone living in your household, their relationship and date of birth.
- Beside each individual's name, list their employer or source of income. For example, you may receive child support or payments for a child or children, so you would enter "Child Support" as the source of income beside the child's name. Another example: You or a household member may receive alimony, survivor, or welfare payments, so you would list the source of income by that person's name.
- Finally, list the amount you received for the last 4 weeks by each person. ***GROSS EARNED INCOME*** is salary/wages before any withholdings for taxes or other benefits. ***GROSS UNEARNED INCOME*** includes benefits paid to any individual such as Worker's Compensation, SSI, Child Support, Unemployment, or on-going support from anyone not included in the household.

Household Information					
Name	**Relationship**	**Date of Birth**	**Employer or Source of Income**	**Gross Earned Income for the last 4 weeks**	**Gross Unearned Income for the last 4 weeks**
Self					
Spouse/Domestic Partner					
Child					
Child					
Child					
Child					
Other					
TOTAL				Total	Total

CERTIFICATION: I certify that **I do not have health and accident insurance, Medicaid, Medicare or other benefits that cover my medical care** for which I have not provided information. I further certify that the above information is correct to the best of my knowledge and that the documentation provided is complete and accurate. I acknowledge that it has been explained to me that failure to provide acceptable proof of income WILL result in my/my family being ineligible for fee discounts and that I will be classified as a full pay patient. I further acknowledge that failure to provide MedLink Georgia, Inc., with an update on my financial status may result in my inability to receive care under the fee discount program. ***I understand and acknowledge that falsification of any information contained on this form constitutes fraud and is punishable by either a fine or imprisonment, or both.***

I have been made aware self-declaration is valid for only 30 days and that proof of income is required to continue receiving discounts.

SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY

INSTRUCTIONS: Enter the date and transfer the household size and income information. Calculate the weekly, monthly, or annual amount and use the current Federal Poverty Table to enter the Sliding Fee discount. Finally enter the source documentation copied and filed that was used to verify the information. When complete, your signature certifies that you verified the information and entered the information correctly to the best of your knowledge. Willfully falsifying information or participating in fraudulent activities to reduce payments shall result in disciplinary action up to and including termination.

Date	House-hold Size	Total Earned Income	Week/ month/ year	Total Unearned Income	Week/ month/ year	Total Household Income	Week/ month/ year	SFS	How Verified?	By Whom?

Next Review Date: 07/19/2024