Mountain Medical Center

FINANCIAL STATEMENT FOR SLIDING SCALE APPLICATION

Policy: It is the policy of Mountain Medical Center to provide essential medical services regardless of the patient's ability to pay. Discounts are offered based upon household income and size. 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 may be eligible for Medicaid, it is strongly recommended that the applicant first apply for Colorado State Medicaid (First Health Colorado) for more comprehensive medical coverage. This only applies to charges for the office visit at this office. All labs, tests, and charges from other doctors or hospitals are separate.

General Instructions: Please complete the form in its entirety, sign at the bottom, and return it to the clinic prior to your scheduled appointment. Please be aware that if you qualify for a Sliding Scale, *that scale will apply only to office visit charges* and not to additional laboratory testing or procedures performed at other entities. Medication samples will also be provided, when available, without charge.

Name (head of household)	Address	Phone	Soc. Sec. #	Date of Birth
Employer Name & Address		Phone	Occupation	How Long
Pay Day	Take Home Pay Per Payday		Monthly Take Home Pay	
Name of Spouse	Address	Phone	Soc. Sec. #	Date of Birth
Employer Name & Address		Phone	Occupation	How Long
Pay Day	Take Home Pay Per Payday		Monthly Take Home Pay	

Family Status (check one)

□ Single □ Married □ Separated □ Divorced □Widow □Widower

Number of persons in your household that you support:

Adults_____ Children_____ Ages_____

Family Member's Name	Social Security or Alien Number	Date of Birth

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HOUSEHOLD INCOME List all Income On a Monthly Basis				
Source of Income	**Self**	**Spouse**	**Other**	**Total**
Gross wages, salaries, tips, etc.				
Self Employed Income				
Social Security, pension, annuity, & veteran's benefits				
Unemployment				
Alimony, Child Support, military family allotments, survivor benefits				
Workman's Compensation				
Rent, interest, dividend, royalties, trusts, and other income or assistance				

I/we hereby certify that the information listed herein is true and correct to the best of my/our knowledge and give Mountain Medical Center my/our permission to verify any information listed.

Date Signature

Date Signature

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's License, birth certificate, employment ID, social security card, or other		
Income: Prior year tax return & three most recent pay stubs		

Thank you for your completed application.

You will be notified within five business days of the acceptance/rejection of your application.

Office Use Only

Patient Name: Discount: Approved By: