*PLEASE RETURN APPLICATION IMMEDIATELY TO ENSURE ACCURATE PROCESSING*

# APPLICATION FOR SLIDING FEE SCALE

**FOR OFFICE USE ONLY**

Verify SS# on Maryland Medicaid EVS Website (if applicable).

Not Eligible at Time of Service – Print Out Sheet & Attach

**" PLEASE PRINT "**

Date: / / Patient’s SSN / ITIN #: Patient’s Name: Patient’s Date of Birth: / / Responsible Party / Spouse Name: Responsible Party / Spouse Date of Birth: / /

Responsible Party/ Spouse Social Security #:

Street Address:

City: State: Zip Code: Phone:

Do you, or the patient you represent, have medical insurance?  Yes  No

If YES, please provide your insurance card to the front desk representative.

Have you applied for Medical Assistance?  Yes  No

If eligible, please provide Medical Assistance Member #:

Are you a Maryland resident?  Yes  No

IF YOU **DO NOT HAVE INSURANCE**, PLEASE ASK FOR ASSISTANCE FROM THE PROGRAM DIRECTOR.

Have you applied for MCHP (Maryland Children's Health Program Yes  No

Do you have a State of Maryland pharmacy card?  Yes  No

If yes, list identification #:

Eligibility for InnerSourced Solutions sliding fee scale financial assistance is based on income levels relative to the federal poverty guidelines published annually and the number of individuals living in your household. Certain sources of income are excluded from the calculation of household income (see below).

Please list the following MEMBERS of your household (self, spouse, significant other, and children, including step- children and legally adopted children, up to 18 years of age) and list ALL income earned by the listed members.

(Proof of income for all listed must be returned within 7 days or at next scheduled appointment, whichever comes first.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Relationship | DOB | Social Security # (if applicable) | Yearly Income |
|  | SELF |  |  |  |
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Comments:

If no members of your household earn income used to calculate eligibility for the sliding fee scale, please check the box below and the appropriate box within the Means of Support.

 I attest that all members of my household have **NO INCOME**.

# Please note that all applications must be updated annually.

**Documents Accepted as Proof of Income (POI): If You Attest to No Income, Please Check Means of Support:**

 Current Pay Stubs-within 90 days (minimum: 1 pay stub)  Disability

 W2 Tax Form  Child Support

 Tax Return Form #1040 (Line 9) **(total income)**  Workers Compensation

 Tax Return Form #1040SR (Line 9) **(total income)**  Temporary Cash Assistance

 Social Security (Staff: READ Contents of Letter)  SSI (Supplemental Security Income)

 Unemployment (for 6 months)  Social Security Disability

 Letter from Employer  Live with other family member

 Other

I certify under penalties of perjury, that the above statements are true, accurate and complete to the best of my knowledge and belief.

Applicant / Guarantor’s Signature



Qualifying Level:

 Nominal

 Level I

 Level II

 Level III

Front Desk Specialist Printed Name:

Front Desk Specialist Signature: Date:



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Monthly: |  |  | X | 12 | = |  |
|  | # in Household | Gross |  | 12 mo. |  | Total Amount |
| Weekly: |  |  | X | 52 | = |  |
|  | # in Household | Gross |  | 52 weeks |  | Total Amount |
| Bi-Weekly: |  |  | X | 26 | = |  |
|  | # in Household | Gross |  | 26 weeks |  | Total Amount |
| Annual: | # in Household | Gross | X | 1  1 year | = | Total Amount |