



Sliding Discount Fee Schedule Application

It is the policy of Aviva Health to provide patient-centered primary care regardless of the patient's ability to pay. Discounts are offered based upon household income and the number of persons living in the household. A sliding fee schedule is used to calculate the basic discount and is updated each year using federal poverty guidelines. Once approved, and based on your source of income, the discount will be honored for up to one year from the date of application, after which the patient must reapply.

A completed application including verification of income must be on file and approved by the business office before a discount will be applied. If the applicant is eligible for other assistance programs, such as the Oregon Health Plan, Aviva staff is available to assist the applicant with applying for these in addition to the Sliding Discount Fee Schedule offered by Aviva Health.

Please complete the following information:

I. Patient Information

Patient Name:	Last	First	MI
Address:	Street	City	State Zip Code
Date of Birth:	Primary Care Physician (PCP)		

II. Guarantor Information

Name:	Last	First	MI
Address:	Street	City	State Zip Code
Telephone Number:	Home/Cell	Work	Date of Birth

III. Household Size Information – List all individuals in the household *

1.Name/Relationship	Date/Birth	Age	4.Name/Relationship	Date/Birth	Age
2.Name/Relationship	Date/Birth	Age	5.Name/Relationship	Date/Birth	Age
3.Name/Relationship	Date/Birth	Age	6.Name/Relationship	Date/Birth	Age

** Please attach a separate sheet with additional dependents if you need more room*

(For Office Use Only)

Sliding discount rate: A B C D F Z

Self-Declared _____ Applied for OHP Y N Date _____

Application date: _____ Expiration Date: _____ Mercy Slide _____

Total Mo. Income: _____ # of Household Members _____

Staff member completing form: _____ Date: _____

IV. Household Earnings Information – Please indicate ALL people living in your household who contribute financially, including applicant. Include anyone at least 18 years of age or older who reside in the household and contribute to the basic living expenses of the household (including yourself.) Income includes gross (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, pensions and/or IRA distribution income or other retirement income, etc. (see instructions for complete list.)

Household Members	D/Birth	Age	Source of Income or Employer	Monthly Gross Income
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Total Monthly Income \$ _____

VI. Additional Information

Are you currently receiving Food Stamps (SNAP)? YES NO

Are you currently receiving TANF? YES NO

If you checked yes to one of the above boxes and wish to qualify for the 30% discount only, you must attach your letter of eligibility.

VII. Required Information – Must be attached to this application (SEE INFORMATION FOR MORE DETAIL)

Please check that you have attached the following documentation – Aviva Health CANNOT, by federal statute, provide you with a discounted fee without proof of qualifying income:

Copy of Previous Year’s Tax Return Copy of Paystubs Showing Income YTD

SNAP or TANF Eligibility Letter* (if checked) Other

*Providing a current eligibility letter for SNAP or TANF will automatically qualify applicant for the Slide D Discount. If applicant is eligible for a greater discount based on income and household size and provides proof of income in addition to a SNAP or TANF eligibility letter, the greater discount will be applied.

To the best of my knowledge, the above information is accurate and complete for all members of my household. (Please sign, date, and print your name) _____

This application process was discussed with the patient by: (Staff – please sign, date, and print your name) _____

AVIVA HEALTH

AUTHORIZATION TO RELEASE FINANCIAL INFORMATION

I understand that once approved, this Application for Reduced Charges may qualify the members of my household for charity care through Mercy Medical Center.

I authorize representatives of Aviva Health to release any information, including proof of income, to Mercy Medical Center representatives for the purpose of verifying charity care eligibility.

Signature: _____ Date: _____
(Responsible Party)

OR

I waive the opportunity to be considered for charity care through Mercy Medical Center at this time.

Signature: _____ Date: _____
(Responsible Party)

Signature: _____ Date: _____
(Aviva Health staff member assisting with completion of this form)