CCRH
Citrus County Rural Health

Sliding Fee Scale Discount Program

Discount Schedule Eligibility Worksheet

Name: _____ Date of Birth: _____ SSN: _____

You must provide proof of income to qualify for the discount schedule. This information must be updated at least annually, and anytime your household income size and/ or medical insurance status changes. You will be responsible for the full amount of the visit and the discount will not be applied to your account until you give CCRH the required proof of income. If proof of income is given to us within 30 days of the visit, and if you are eligible, the discount will be applied retroactively, and all following visits will be discounted.

List your name and the names of ALL individuals who lives with you. Name, Relationship, Age, Gender, Date of Birth, Annual Income, Employer, or Self-Employed. If you need more space, please continue on the back of this form.

(List your name and the names of ALL individuals who lives with you)

Name	Relationship	Age	Gender	DoB	Annual Income	Employer

	Yes	No
Are you currently employed?	◯	◯
Do you work seasonally only?	◯	◯

How much money do you and all who live in your household bring in per:	Week	Month	Year
	$	$	$

If you are not working , how are you meeting your monthly expenses? Please check an option	Savings	Borrowing	Other
	☐	☐	☐

	Yes	No
Do you have health insurance? If yes, what is the deductible amount? $ _____	◯	◯
Do you have Medicaid?	◯	◯
Did you apply?	◯	◯
Were you denied Medicaid Insurance?		
Do you have Medicare?	◯	◯
Are you eligible to apply?	◯	◯

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List **ALL** that you, and those living in your household receive:

(Amount per month/year Salary or wages)

$_____ Unemployment

$_____ Social Security

$_____ Pension/Retirement

$_____ Rental Income/Dividends

$_____ Interests

$_____ Spousal Support

$_____ Child Support

$_____ Foster Care

$_____ Public Assistance *(ATAP)*

$_____ Permanent Fund

$_____ Longevity Bonus

$_____ Self-Employed *(Net Amount)*

$_____ Worker's Comp Benefits

$_____ Disability Benefits

$_____ Other

$_____ Total Monthly/Annual Household Income

PLEASE READ AND SIGN

I authorize all government agencies, employers and any companies, agencies, or persons listed herein to provide information about me to Citrus County Rural Health, Inc. Health Center (CCRH), the State of Florida, and/or the federal government. I also authorize CCRH to disclose this information to agencies, third party payers and other health care providers as necessary to qualify me for reduced fees. I certify that the statements regarding the persons and income in my household are true and correct to the best of my knowledge. I further understand if any information is found to be inaccurate, I may be denied a discount and/or subject to legal action for knowingly providing false information. I agree to notify CCRH of all changes in income, address, living arrangements, number of household members, and/or other circumstances. I understand that the information given above will be kept confidential except for the purposes noted above and not be release without my writen permission. I also understand that if I do not agree with any decision made concerning this application, I have the right to ask in writing for a review by the CEO of Citrus County Rural Health, Inc.

Signature: _____ Date: _____

FOR OFFICE USE ONLY	
Total Annual Income:	# of Family Members
Verified By:	Date:
Verified with: ☐ Pay Stubs | ☐ Tax Forms | ☐ EVF | ☐ CVF | ☐ Other_____	
Proof Returned Date:	Discount Effective Date:
Qualified?: ☐ Yes ☐ No	Discount%: ☐ 100% ☐ 75% ☐ 50% ☐ 25%
Requalify Date:	