VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

At the Ventura County Health Care Agency, we believe in providing essential services to all patients regardless of their ability to pay. We offer discounts based on family income and size. To determine eligibility, please complete the following information and return it to the front desk.

The data gathered on this form will only be used so that we can better meet your healthcare needs. This information will not be used to withhold or deny services to you.

Patient Name: _____ Date of Birth_____

1. Are you covered under Medi-Cal, Medicare, or any other insurance? Yes No
2. If insured, what is your annual deductible? $ _____

How many related people live in your household, including yourself and dependents under 18? _____

Income Verification

Include estimated income from all related persons in household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans' payments, net business or self-employment income, alimony, child support, military payments, unemployment, public aid and other.

Source	Weekly Income	Biweekly Income	Monthly Income	Total Annual Income
Wages				
Disability				
Social Security				
Unemployment				
Workers Compensation				
Family Support				
Rental Income				
Other Income				
Total Income				
Multiply for Annual Income	**x 52**	**x 26**	**x 12**	
Total Annual Income				

Patient Acknowledgement Statement

The discount will apply to all services received at our clinics but does not include services purchased from outside our clinics, such as specialized diagnostic testing, CT scans, MRIs, pharmaceuticals, dental lab work and similar services. This form must be completed annually and/or if there are any changes to your income or family size.

I certify that the family size and income information shown above is correct, and I will update the health center in the event there is a change in my income or insurance status. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

I acknowledge that I am financially responsible for all or a portion of my care, and I will be asked to provide payment at the time of service.

Patient Signature: _____ Date: _____

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Office Use Only Section Medical Record No_____

I received the following income verification documents (Check all that apply /copies to be scanned with application):

☐ Recent Pay Stub ☐ W2 ☐ Tax Return ☐ Bank Statement ☐ Employer Letter

☐ Benefit Statement (unemployment, workers comp, Social Security)

☐ Self-Declaration Form ☐ Other: _____

Program for which patient qualifies: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Expiration/Renewal Date: _____

Employee Certification Statement

I certify that I asked the applicant about all sources of income received by the household. The information reported on this form was provided solely by the applicant and reflects the information reported to me.

Staff Printed Name_____ Signature: _____ Date: _____