Greetings,

Thank you for inquiring about the Slide Fee Discount Program offered at AmberMed Medical Clinic. The Slide Fee Program helps reduce the cost of services for you and your household members. If interested, you should complete the Slide Fee Application and sign the Declaration of Income/No Income form and return them to the AmberMed Medical Clinic within 45 days of the first eligible visit.

Eligibility for the Slide Fee Discount Program is determined by two factors: household size and income.

A household is defined as "all person(s) related by birth, marriage, or adoption who reside together, dependents, and others in the same tax household." Unrelated persons in the home or other tax filers are not included but may apply separately for themselves and their dependents.

Households should provide verification of income from all sources, whether "earned" or "unearned," within the 45 day time frame. Examples of "earned" and "unearned" income are below. Note, this list is not exhaustive of all income sources. Patients may be asked to provide additional information to verify the household's income.

Earned Income:	**Unearned Income:**
Wages	Unemployment
Paystubs	Social Security (SSDI, SSI, Retirement)
W2s	Alimony
Employer Wage Statements	Gift
Self-employment income	Retirement/pensions/IRA/private distributions
Current tax returns (all schedules)	VA Benefits/Military Pay
Bank Statements	Workman's Compensation

If you have questions or would like to schedule an appointment to discuss your options, please call the AmberMed Medical Clinic at (785) 675-3018.

AmberMed Medical Clinic offers the Slide Fee Discount Program to any interested patient regardless of their insurance status or ability to pay for services. Patients are expected to pay the nominal fee for services rendered.

AmberMed

The Sliding Fee Scale is available to all patients who meet the income and household guidelines. Proof of gross income is required within 45 days for all household members.

VERIFICATION OF **GROSS INCOME** MUST BE PROVIDED TO PROCESS APPLICATION

Applicant Name _____ Social Security # _____

Physical Street Address _____ Mailing _____

City, St, Zip, County _____ Phone Number _____

LIST BELOW **ALL** MEMBERS OF HOUSEHOLD. LIST **ALL GROSS INCOME** RECEIVED BY **EACH** PERSON IN HOUSEHOLD.

List all Household Members NAME (Include Applicant)	TYPE OF MEDICAL COVERAGE	RELATIONSHIP To Applicant	BIRTH DATE	Estimated Gross Income (before taxes)	SOURCE NUMBER

Source of income (list number on line above)

1. Wages
2. Unemployment
3. Social Security
4. Disability
5. Pensions/Retirement
6. Alimony
7. Other

Do you have health insurance or dental insurance coverage? No: _____ Yes: _____

If yes, what kind? Health Insurance: _____ Medicaid: _____ Medicare: _____ Dental: _____

I, declare the information provided is true and correct to the best of my knowledge. I authorize AmberMed to verify the information provided to complete my application. I understand I may have to provide additional documentation to determine my household's eligibility under the Slide Fee Discount Program policy. If any information provided is inaccurate, incomplete or falsified I will be responsible for the entire balance and any prior payment arrangements or discounts may be void.

Applicant's Signature X _____ Date _____

(Clinic Office Use Only)

Total Family Income: _____
Applicable Poverty Level: _____
Category (circle one): **A B C D E**
Nominal Fee: Med____BH____Den____

Income Verification Type (circle one):
1040 W-2 Wage Statement Benefit Letter(s) Bank Statement(s)
Other: _____

App Completed Date: _____ Reviewed by: _____
Approval Date: _____ Approved by: _____
Effective Date: _____ Expiration Date: _____

One Time Self Declaration of Income

Declaration of Income

Proof of income is required for individuals requesting financial assistance on the Slide Fee Discount Program. I am attesting for my **first** visit that my income is _____and the number of people in my household is____. I agree to bring in financial information **prior** to my next clinic visit. If my income or insurance status changes, I will contact AmberMed staffimmediately.

Patient's Name Responsible party's Signature Date

No Income Declaration

Proof of income is required for individuals requesting financial assistance on the Sliding Fee Scale Program. I currently do not have any source of income. If my income or insurance status changes, I will contact the AmberMed staff immediately.

Patient's Name Responsible party's Signature Date