Charitable Care Application

VIOLA STARTZMAN CLINIC

The Viola Startzman Clinic is committed to providing care to patients who cannot afford it. This requires a partnership between the clinic and the patient, because the clinic DOES NOT receive state or federal funds to offset this care. All discounted care is provided through the generosity of our community. To help us stretch the funds we have available, we need to make sure discounts are given only to those who have no other option to pay for care.

Patient Name: _____ Social Security #_____

Date of Birth_____ Phone Number_____

Address:_____ City:_____ State:_____ Zip:_____

County of Residence: ☐ Wayne County ☐ Holmes County ☐ Other_____

Marital Status: ☐ Single ☐ Married ☐ Divorced Total Family Size*_____

**For the purposes of this program, family is defined as the patient, the patient's spouse and any children under 18 who live with the patient.*

Documentation of Family Income

Please list ALL family members and their monthly income below (see above definition on who to include, and please include everyone, even if they have no income). Sources of income include: Employment or unemployment income, child support, spousal support, disability benefits, retirement or pension income, workers compensation, social security, SSI, veterans benefits.

Name	Patient of VSC?	Relationship	Age	Income Source (see source list above)	Monthly Income
1.	☐YES ☐NO	Self			$
2.	☐YES ☐NO				$
3.	☐YES ☐NO				$
4.	☐YES ☐NO				$
5.	☐YES ☐NO				$
6.	☐YES ☐NO				$
			Total Monthly Family Income		$

If family income is $0, please tell us how you are surviving (where are you living, how do you get food, etc.):

If you have any health insurance, please complete this section. If you are uninsured, skip to the next box:

Insurance Company Name_____ ID #_____

Individual Deductible:_____ Family Deductible:_____ Office Visit Co-pay:_____

Does your insurance cover dental care? □ Yes □ No

What are you having trouble affording?
□ Deductibles (the amount you have to spend before your insurance kicks in)
□ Co-Pays (the amount you have to pay at each appointment)
□ Dental Care (I have health insurance but no dental insurance)

Staff use: Date insurance verified_____ (attach eligibility report & plan summary to application)

If you have NO health insurance, please complete this section.

Have you been screened for Medicaid eligibility in the last 3 months? □ Yes □ No
Have you applied for insurance on the Marketplace in the last year? □ Yes □ No
Does your employer offer insurance? □ Yes □ No
If yes, why are you not on their insurance?

Is there another reason you don't have insurance?

Staff use: Date of Medicaid screening_____ (attach denial letter)
Date of Marketplace screening_____ (attach plan offers)

Please attach copies of the following:

□ Copy of the front and back of your insurance card, if you have one
□ Last year's tax return, or a signed IRS form4506T verifying you did not file taxes
□ 2 months worth of paystubs
□ Proof of residency (utility bill, phone bill, lease agreement, etc.)

By signing below, I certify that everything on this application and any attachments is true and complete to the best of my knowledge. I understand that discounts won't go into effect until I have turned in all the required forms. I understand that any fees I am responsible for are due before each visit. I understand that it is my responsibility to update this information annually and if anything changes.

Please remember that even if you are eligible to receive free or discounted care at the Viola Startzman Clinic, this discount only applies to services we can provide here in the clinic. If you need a referral to a specialist or for X-rays or other tests, you will need to apply for discounts at the offices you are referred to. It is always best to have health insurance to cover all of these services if you need them.

Signature: _____ **Date:** _____
Relationship to patient:_____

Staff use: Verified by_____ Date_____ Fee Level_____