Outpatient Medical Center, Inc.
Application for Discounted Services

Applicant's Name (Last, First, Middle):	Home Telephone #:	Daytime Phone #:	Alternate Phone #:
Mailing Address:	City:	State:	Zip code:

Physical Address: ☐ Same as Mailing

Have you ever used another name: ☐ Yes ☐ No
If yes, Previous Name Used (Previous Last, Nickname)
_____

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Separated ☐ Life Partner

Please Fill In Line (A) Below About Yourself. List Below (Lines B-G) Every Person Who Lives In The Same Household As You:

Name (Last, First, Middle)	Relationship To You	DOB	Sex	Race (See Below)	Ethnicity (See Below)	Social Security #
(Applicant) A.	Self					
B.						
C.						
D.						
E.						
F.						
G.						

Race :
A – Asian
B – Black / African American
NA – American Indian / Alaskan Native
NH – Native Hawaiian
O – Other
OPI – Other Pacific Islander

Ethnicity :
C – Cuban
CND – Choose Not to Disclose
LH – Latino or Hispanic
MOR – More Than One Race
NH – Not Hispanic
O – Other
PR – Puerto Rican

List All Of Your Household's Income Below:

Name of Person Working / Receiving Money	Name of Employer. Person, or Agency that Provides Money	How Often Received	Amount Received	Social Security, Social Security Disability, TANF, Self-Employment (Enter Claim #)

Total Income: $_____

Does Anyone Have Health Insurance (Private Insurance, Medicaid, Medicare, CHIP, etc.) If So, Please List Below:					
Name of Person Insured	**Name of Policy Holder**	**Name of Employer Providing Insurance**	**Name of Insurance**	**Policy Number**	**Insurance Company Phone #**

The statement I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give OMC staff my information necessary to prove statements about my eligibility. I will cooperate fully with a quality control review or audit.

I agree to report any of the following changes within 14 days:

- Income
- Number of people who live with me
- Application for or receipt of SSI, TANF, or Medicaid
- Name/Address/Telephone Number

I understand this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt of stopping assistance.

I understand that by signing this application, I am giving OMC the right to recover the cost of health care services provided by OMC from any third party. I agree to give OMC my information required to identify and locate all other sources of payment for health care services.

If I qualify for discounted services and it is later determined that the information or proof I provided on this application is false, I may lose my discount, may be barred from reapplying for 6 months, and may be required to pay OMC for any services rendered at 100% of the cost. I understand that my failure to meet the obligations set forth may be considered willful withholding of information and can result in the recovery of any loss by repayment, or by filing criminal or civil charges against me.

By signing this document, I attest that each answer is complete and correct to the best of my knowledge and belief.

_____ _____

Applicant's Signature **Date**

FOR OFFICE USE ONLY:

ITEMS NEEDED IF APPLYING FOR A DISCOUNT: (Please Check All Provided By Applicant)

☐**Paycheck Stubs (1 Month Consecutively)**
- **Paid 1 x/Month – Last Check Stub**
- **Paid 2 x (Bi-weekly)/ Month – Last 2 Check Stubs**
- **Paid Weekly – Last 4 Check Stubs**

☐**Child Support Documentation**

☐**Unemployment Benefits Letter**

☐**Social Security Disability Letter**

☐**Retirement Income Award Letter**

☐**Employer Wage Verification Letter – (Company Letterhead with Employer Signature)**

☐**Wage & Tax Statement for Self-Employment (1099)**

☐**Food Stamps / SNAP Award Letter**

☐**Supplemental Social Security Income (SSI) Letter**

☐**Federal Income Tax Returns (1040)**

☐**Worker's Compensation Payments Award Letter**

Today's Date: _____

Based on the information submitted to us and scanned into the system, _____,
(applicant's name)

has been deemed eligible for a _____% discount of charges billed, effective _____
(date)

to _____ (1 year).
(date)

Prepared by (PSR): _____

Approved by (Clinic Director): _____