



# Outpatient Medical Center, Inc.

## Application for Discounted Services

<b>Applicant's Name (Last, First, Middle):</b>	<b>Home Telephone #:</b>	<b>Daytime Phone #:</b>	<b>Alternate Phone #:</b>			
<b>Mailing Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip code:</b>			
<b>Physical Address:</b> <input type="checkbox"/> Same as Mailing						
<b>Have you ever used another name:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, Previous Name Used (Previous Last, Nickname)</b> _____		<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Life Partner				
<b>Please Fill In Line (A) Below About Yourself. List Below (Lines B-G) Every Person Who Lives In The Same Household As You:</b>						
<b>Name (Last, First, Middle)</b>	<b>Relationship To You</b>	<b>DOB</b>	<b>Sex</b>	<b>Race (See Below)</b>	<b>Ethnicity (See Below)</b>	<b>Social Security #</b>
(Applicant) A.	Self					
B.						
C.						
D.						
E.						
F.						
G.						
<b>Race :</b> A – Asian B – Black / African American NA – American Indian / Alaskan Native NH – Native Hawaiian O – Other OPI – Other Pacific Islander				<b>Ethnicity :</b> C – Cuban CND – Choose Not to Disclose LH – Latino or Hispanic MOR – More Than One Race NH – Not Hispanic O – Other PR – Puerto Rican		
<b>List All Of Your Household's Income Below:</b>						
<b>Name of Person Working / Receiving Money</b>	<b>Name of Employer. Person, or Agency that Provides Money</b>	<b>How Often Received</b>	<b>Amount Received</b>	<b>Social Security, Social Security Disability, TANF, Self-Employment (Enter Claim #)</b>		
<b>Total Income: \$ _____</b>						

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:**

**The following checked items were used to determine the % discount provided below**

- |   |  |
|---|--|
| <input type="checkbox"/> Paycheck Stubs (1 Month Consecutively)   | <input type="checkbox"/> Child Support Documentation       |
| • Paid 1 x/Month – Last Check Stub  | <input type="checkbox"/> Unemployment Benefits Letter      |
| • Paid 2 x (Bi-weekly)/ Month – Last 2 Check Stubs  | <input type="checkbox"/> Social Security Disability Letter |
| • Paid Weekly – Last 4 Check Stubs  | <input type="checkbox"/> Retirement Income Award Letter    |
| <input type="checkbox"/> Employer Wage Verification Letter – (Company Letterhead with Employer Signature) |  |
| <input type="checkbox"/> Wage & Tax Statement for Self-Employment (1099)                                  | <input type="checkbox"/> Food Stamps / SNAP Award Letter   |
| <input type="checkbox"/> Supplemental Social Security Income (SSI) Letter                                 | <input type="checkbox"/> Federal Income Tax Returns (1040) |
| <input type="checkbox"/> 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): \_\_\_\_\_

Reviewed by (PSM): \_\_\_\_\_

Approved by Chief Compliance Officer: \_\_\_\_\_