# 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<br>If yes, Previous Name Used (Previous Last, Nickname)<br>_____ | Marital Status:<br>☐ Single ☐ Married ☐ Divorced ☐ Widowed<br>☐ 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)<br>A. | Self | | | | | |
| B. | | | | | | |
| C. | | | | | | |
| D. | | | | | | |
| E. | | | | | | |
| F. | | | | | | |
| G. | | | | | | |

| Race : | Ethnicity : |
|---|---|
| A – Asian | C – Cuban |
| B – Black / African American | CND – Choose Not to Disclose |
| NA – American Indian / Alaskan Native | LH – Latino or Hispanic |
| NH – Native Hawaiian | MOR – More Than One Race |
| O – Other | NH – Not Hispanic |
| OPI – Other Pacific Islander | 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 #** |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

I understand that, if I receive a discount, will will only be applied to charges made after the date of approval. I have given OMC staff the required information necessary to determine my eligibility. I agree to report any changes within 14 days to my income, the number of people who live with me, application for or receipt of SSI, TANF, or Medicaid, my 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 I have received a Patient Rights and Responsibilities and understand my financial obligation. I acknowledge and understand that any discount i am eligible for may only be applied for charges that I am responsible for after all available third party insurances have paid their portion, if applicable.

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 will 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**

**☐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 (Patient Services Representative): _____**

**Reviewed by (Patient Services Supervisor): _____**

**Approved by CEO Designee: _____**

# ITEMS NEEDED TO REGISTER AS A OMC PATIENT AND ITEMS NEEDED IF APPLYING FOR A DISCOUNT

## THIS SECTION FOR ALL PATIENTS

## A. Picture Identification

**Present ONE of the following items to prove your identity:**

Driver License or State Issued ID
Passport
U.S. Military ID
U.S. Permanent Resident Card
Consular or International ID Card
Foreign Government-Issued ID
U.S. Immigration Documents
Birth Certificate (children)
High School or College Student ID
School Records (children)
Employer-Issued Identification Card
Transportation Worker ID Credential Card (TWIC)
County Indigent Healthcare Program ID card

We want to protect your information and your identity. This helps prevent someone else pretending to be you and taking advantage of your eligibility or stealing your identity.

## B. Proof of Address

**Present ONE of the following items with your name to verify your current address:**

Current Drivers' License
Current State-Issued ID
Consular or International ID Card
School Registration Records (children)
Voter's Registration
Automobile Insurance Documents
Business Mail postmarked within 30-days
Utility Bill (electric, water, gas, phone/cell, cable TV)
Current Lease Agreement (signed)
Federal/State Housing Documents
Mortgage Documents (signed)
Property Tax Documents (within 12 months)

## THIS SECTION ONLY FOR PATIENT SEEKING A DISCOUNT

## Sliding Fee Discounted Program (Requires ALL Sections A, B & C)

## C. Household Income

**Document by presenting these items for each household member's income:**

Paycheck stubs (1 month consecutively)
PAID 1X/Month – Last check stub
PAID 2X/Month – Last 2 check stubs
PAID Bi-Weekly – Last 2 check stubs
PAID Weekly – Last 4 check stubs
Employer Wage Verification Letter
(company letterhead with employer signature)
Child Support Documentation
(Attorney General)
Unemployment Benefits Letter
Social Security Disability Letter
Supplemental Social Security Income (SSI) Letter
Workers' Compensation Payments Award Letter
Federal Income Tax Returns (1040)
Wage & Tax Statement for Self-Employment (1099)
Retirement Income Award Letter
Food Stamps/SNAP Award Letter