Midwest Refuah Health Center

Sliding Fee Scale Discount Application

Today's Date: _____

Midwest Refuah Health Center (MRHC) is committed to providing high-quality care regardless of your ability to pay. Discounts are offered based on household income and the number of people living in the household. Once approved, discounts will be honored for one year from the date of application.

If you are **uninsured**: Your fees from MRHC services may be discounted based on the information provided here.

If you are **insured**: Based on your income, you may qualify for discounted copays and other out-of-pocket expenses. Your out- of-pocket expenses for MRHC services will be based on the information provided here.

If you are not completing a full application today, please check one of the boxes below.

- ☐ **I decline to apply for the sliding fee scale**. By declining, I acknowledge I will be responsible for the full fee of any services not covered by insurance, including out-of-network charges.
- ☐ **I have not yet provided proof of income to support my sliding fee application**. I acknowledge that I will be charged full fees after 7 days if I do not provide proof of income and/or expenses.

Household Member Information. An approved sliding scale discount applies to all household members.

Name	Date of Birth	Name	Date of Birth

MRHC OFFICE USE ONLY:

	Initial PSR Review	Final MRHC Review Based on Supporting Documentation Received	
Family Size:			
Annual Income:			
Annual Cost of Living:			
Annual Income-Annual Cost of Living:			
Sliding Fee Category:			
PSR Reviewed By:			**Date**
Final MRHC Approval By:			**Date**

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Household Income	Self		Partner		Other	
	Amount	Frequency (weekly, yearly, etc.)	Amount	Frequency	Amount	Frequency
Gross Wages, Salaries, Tips, etc.						
Income from business, self-employment (1099), or dependents						
Unemployment compensation, workers' compensation, Social Security, disability income, SSI/SSDI, public assistance, veterans' payments, survivor benefits, pension, or retirement income						
Child Support, alimony, assistance from outside the household, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, or other misc. source.						
Total Annual Income						

Household Expenses	Self		Partner		Other	
	Amount	Frequency (weekly, yearly, etc.)	Amount	Frequency	Amount	Frequency
Monthly Rent or Mortgage						
Monthly Medical Bill Debt						
Monthly Tuition or Childcare Bill						
Legal Expenses						
Total Annual Expenses						

Other notes or comments:

My signature below certifies that the above information is true and correct. I understand that falsifying information will terminate any MRHC financial assistance. I agree to notify MRHC of any significant changes in my income or household size. I will provide proof of income within 30 days of this application; otherwise, my application will be denied, and I will be charged the full fee for services.

_____ _____

Signature of Patient or Guardian Date