Est. 1993
TREASURE COAST
COMMUNITY HEALTH

TCCH Sliding Fee Discount Program Application

Out of County ☐

Account Number: _____ Application Date: _____

Applicant phone #: _____ Patient Email: _____

☐ New Application ☐ Renewal

Number of people in the household? _____ Insurance Notes: _____

Name	Date of Birth	Relationship	SSN	Employed	Medical Insurance ID	Dental Insurance ID
		Applicant				

If patient does not have medical and/or dental insurance please write n/a in the field

Monthly Gross Income: $_____ Sliding Fee Level: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

Proof of Income: ☐ Tax Forms ☐ Paystubs ☐ Tips ☐ SSI ☐ Child Support ☐ Other: _____

Are you Homeless? ☐ Not Homeless ☐ Homeless Shelter ☐ Transitional ☐ Doubling up ☐ Street ☐ Other
☐ Permanent Supportive Housing ☐ Unknown ☐ Refused

Do you live in Section 8 Public Housing? ☐ Yes ☐ No **Disabled:** ☐ Yes ☐ No

Worker Status: ☐ Refused ☐ Not Migrant/Seasonal ☐ Seasonal ☐ Migrant

Veteran: ☐ No ☐ Refused ☐ Yes **Military Discharge:** ☐ No ☐ Refused ☐ Yes **Discharge Date**: _____

Refugee Status: ☐ No ☐ Yes If yes specify, **Country of Origin:** _____

I understand that I may be responsible for repayment of any discounts granted if we find any of the above information to be incorrect.

Applicant Signature: _____ Date: _____

TCCH Health Navigator Name: _____ Date: _____

N ☐ R ☐ HD #

AUTHORIZATION FOR RELEASE OF PRIVATE INFORMATION

Name:_____ DOB:_____

Address:_____

I, _____, authorize the Indian River County Hospital District ("District") and its Funded Agencies which include the Indian River County Health Department, Mental Health Association, Mental Health Collaborative, New Horizons, Inc., Treasure Coast Community Health, Inc., University of Florida Center for Psychiatry and Addiction, and the Visiting Nurse Association of the Treasure Coast, Inc., and its successors and assigns (collectively "District and its Funded Agencies") to disclose, share, release, communicate, maintain, and share between District and its Funded Agencies, as necessary, private information and documentation (collectively "information") contained in my application for indigent qualification to determine whether I qualify for indigent status as defined by the Indian River County Hospital District's Policy and Procedure Manual for Determining Eligibility of Indigent Care.

This private information I authorize to be released to the District and its Funded Agencies may include, but is not limited to, my name, address, telephone number, social security number, FICO score, gross household income, government monitoring information, government assistance received, tax returns, and payroll information, as well as household financial obligations, and personal assets, as applicable.

I understand that some or all of this information is classified as private information with regard to an individual.

I understand that it is necessary for District and its Funded Agencies to have access to this private information in order to determine whether I am a qualified indigent.

I understand that the District and its Funded Agencies will take reasonable steps to safeguard my private information and will not release it to a third party without my prior consent.

I agree to indemnify and hold harmless the Indian River County Hospital District and its Funded Agencies, its Trustees, officers, employees, contractors, and representatives from liability on account of any injuries, damages, omissions, commissions, actions, causes of action, claims, suits, judgments, and damages, including court costs and attorney fees (for all matters including administrative and litigation and appellate proceedings), accruing as a result of releasing my private information between the District and its Funded Agencies for purposes of determining my eligibility as a qualified indigent, including any negligent act or willful misconduct by the District or its Funded Agencies, its Trustees, officers, employees, contractors, and representatives or any other action arising out of the operation of this agreement.

This authorization will not be valid unless I sign the authorization and will remain in effect until I revoke it in writing and deliver my revocation to the Indian River County Hospital District.

WITNESSES: Dated:_____

_____ _____

Printed:_____ Name:_____

_____

Printed:_____

Attachment #6 Updated
05/2022
Effective 8/1/2022

IRCHD Indian River County Hospital District

APPLICATION
HEALTH CARE FINANCIAL ASSISTANCE ID Program

Applicant Name: _____

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

Mailing Address:_____ City_____, FL/ZIP_____

Street Address: _____ City_____, FL/ZIP_____

How Long a Resident of Indian River County _____ Year(s) _____ Month(s)

Home Phone: _____ Cell Phone: _____

Please list immediate family members living with you.
(Immediate family = You, spouse or significant other, & children)

Family /Personal Information

Family Member Name Include Maiden Name	Relationship	Date of Birth	Social Security #	Medical Insurance Y/N	US Citizen Y/N	Employed Y/N
	APPLICANT					

TOTAL Number of Family Members: _____

Income & Employment Information

Applicant's/Guarantor Occupation	Employer Name & Address	Monthly Income
Spouse Occupation	Employer Name & Address	Monthly Income
Other	Source of Income	Monthly Income

Monthly Deductions for Childcare Expenses / Spousal Support

Court Ordered Child Support $_____ / month

Court Ordered Spousal Support $_____ / month

Comments:_____

_____

_____

I certify that the information listed above is true and correct to the best of my knowledge, I understand that in accordance with SECT.817.50, of the Florida State Statute, providing false information to defraud a hospital for the purpose of obtaining goods or services is a MISDEMEANOR in the second degree. I also understand that any insurance money or liability recovery which may be paid or due me at a later date for services must be paid to Indian River Medical Center. Failure to forward any third party recovery amount to the Medical Center will result in the immediate revocation of the approval for Indigent Care.

_____ _____

Patient Signature Provider Witness Signature Date

** A PROOF OF RESIDENCY IS REQUIRED **

In order for this application to be approved, a photo identification and a current proof of residency must be attached.

Application Check list:

☐ Authorization Release Form

☐ Application for Healthcare Financial Assistance

☐ Applicant's photo ID or12 alternative non-photo IDs

☐ Income Verification for last 4 weeks

☐ Letter of Support (if applicable)

☐ Proof of Residency - Current

☐ Proof of Residency - Current

2 Proof of Indian River County Residency

Documents must match applicant's listed address

☐ Utility Bill ☐ Telephone Bill

☐ Tax Bill ☐ Rent Receipt

☐ Drivers License ☐ Medical Bill

☐ Other_____

FOR OFFICE USE ONLY:

Yearly Income _____ Family Size _____

o **APPROVED**
(Within Income Guidelines & Proof of Residency Attached)

o **DENIED**
Reason:
_____

Patient Sticker or Patient Name, Account #

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Sliding Fee Discount Program
Self-Declaration of Income

I, _____ certify that I am self-employed or have worked odd jobs for cash, for the last _____ months/years.

My average monthly income is $ _____. I have no records, nor have I filed Income Taxes.

Generally, the type of work I do is _____. If you need to verify this information you may contact the following person for a reference:

Name: _____

Address: _____

City: _____

Phone Number: _____

I certify that the information listed above is true and correct to the best of my knowledge, I understand that in accordance with SECT.817.50, of the Florida Statutes, providing false information to defraud a hospital for the purpose of obtaining goods or services is a MISDEMEANOR in the second degree.

I understand that I may be responsible for repayment of any discounts granted if we find your declaration to be incorrect.

_____ _____

Applicant's Signature Date

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Sliding Fee Discount Program
Attested Proof of Residency

Date: _____

I, _____ a resident of Indian River County Residing at:

_____ attest that

_____ has been a resident of Indian River

County for 6 months or more and is known by me to currently reside at:

_____
Address

Person completing this form must attach personal photo identification showing they are a resident of Indian River County*

_____ _____
Printed Name Date

_____
Signature

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Sliding Fee Discount Program
Letter of Support

Date: _____

I, _____ certify that I am supporting/helping Mr./Ms.

_____ to pay his/her expenses in the home, located

at _____.

From: _____ To: _____.

The above referenced person is my _____(relationship).

The above referenced person _____ (does or does not)

reside with me and _____ (is or is not) my

girl/boyfriend and we have no biological or adopted children together.

I understand that signing this letter of support will in no way obligate me to pay for the applicant's healthcare expenses.

Signature: _____

Printed Name: _____

Address: _____

Phone Number: _____

Person completing this form must provide photo ID or have signature notarized.