INFORMATION REQUIRED TO APPLY FOR
SLIDING FEE SCALE PROGRAM

All applicants need to furnish the following documentation at the time of the appointment:

- ***2 proofs of Indian River County residency – Current and 6 Months***
- ***1 photo ID or two forms of verified identification***
- ***Verification of household income for the last 8 weeks***

A proof of residency could be:

- Utility bill*
- Telephone bill*
- Rent Receipt*
- Tax bill
- Homestead exemption
- Drivers license
- Other documents acceptable to the Tax District

P.O. BOXES CANNOT BE USED AS PROOF OF RESIDENCY

Verification of household income must be:

For Working Applicants

1. Last 8 weeks check stubs from employer or statements from employer indicating gross income.
2. For self-employed applicants, copy of prior year Income Tax Form 1040.

For Unemployed Applicants

1. A statement from the applicant explaining how you have been living without any type of income.
2. Letters of Support. If you are receiving help from anyone, they also need to furnish a photo ID and a statement indicating they are helping you.

***If you are collecting unemployment*, then you need to furnish:**

1. Copy of the check or a statement from the Unemployment Office.

For Disabled Applicants

1. A statement from the Disability Office indicating that you are disabled.
2. Proof of the amount of your disability check.

For Social Security Applicants

1. Proof of the amount of monthly check. The Social Security Office will furnish a statement for you.

If you would like to apply for this program, please call: (772)257-8224

If you have any questions, please call (772)257-8224 & ask for the following extension(s): Central Vero: Ext 1261
Oslo Road: Ext 1140
Fellsmere: Ext 1115
Sebastian: Ext 1190
Vero Dental: Ext 1208

YOU MUST PHONE AHEAD FOR AN APPOINTMENT

All residents of the Indian River County could be eligible for the Sliding Fee Scale Program regardless of age, gender, race, or migratory status. Eligibility is based on household income and family size. **Patients who have Medicaid or are potentially eligible for Medicaid will not qualify for this program.** The Sliding Fee Scale Program is good only to cover charges from Treasure Coast Community Health; it does not cover outside services.

APPLICATION FOR
Financial Assistance

Patient Name: _____ Application Date: _____

Marital Status: Single Married Widowed Divorced Separated

Guarantor Name: _____

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: _____ Email Address: _____

Family /Personal Information

Family Member Name Include Maiden Name	Relationship	Age	Date of Birth	Medical Insurance Y/N	US Citizen Y/N	Social Security Number	Employed Y/N
	PATIENT						

TOTAL Number of Family Members: _____

Income & Employment Information

_____	_____	_____
Patient'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 authorize Treasure Coast Community Health (TCCH) to verify all information given. I understand that TCCH will make every effort to keep this information in complete confidence.

I also understand that any insurance money or liability recovery, which may be paid, or due to me later for these services must be paid to TCCH. Failure to forward any third party recovery amount to TCCH will result in rescission of the approval for the Sliding Fee Scale Program.

_____ _____

Patient Signature Date Provider Witness Signature Date

I certify that I am a resident of the Indian River County Hospital District for 6 months or more and that the information given in this application is true and correct. If it is discovered that any information is false, the application may be denied.

_____ _____

Patient Signature Date Provider Witness Signature Date

SLIDING FEE SCALE 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 State Statue, providing false information to defraud a hospital for the purpose of obtaining goods or services is a MISDEMEANOR in the second degree.

_____ _____

Applicant's Signature Date

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:_____

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 / boy friend 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.

Attested Proof of Residency

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)

_____

Signature

_____

Printed Name

_____

Date