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

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 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

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

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

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<tr>
<th>Family Member Name Include Maiden Name</th>
<th>Relationship</th>
<th>Age</th>
<th>Date of Birth</th>
<th>Medical Insurance Y/N</th>
<th>US Citizen Y/N</th>
<th>Social Security Number</th>
<th>Employed Y/N</th>
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**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

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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 Statute, 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

TCCH #1013 v1 Effective 1.18