MosaicMedical
Quality Care For All

Sliding Scale Eligibility Declaration

Applications will not be accepted unless form is filled out completely and proof of income is provided.

_____

Applicant Name (please print)

_____

Physical Address | City | State | Zip Code

_____

Mailing Address (If different from above) | City | State | Zip Code

Primary Phone (_____) _____ Other or Message Phone (_____) _____

Proof of Income Verification: These are the types of proof we accept, ***please submit all that apply***:

- **Previous year's tax return**. If prior to April 15th, prior year return is acceptable. If after April 15th, current year's return.
- **Paycheck stubs.** Minimum of one month, preferably three months' worth of the most recent pay stubs.
- **Statement from employer as proof of wages.** Only when check stubs are not used. *Employer to complete Attestation.*
- **Statement from unemployment services, Social Security Income or food stamps award letter.**
- **Statement of income determination from the Department of Housing or Energy Assistance.**
- **Self-Declaration/Social Declaration.** *Patient to complete Attestation.*

Household Information (must be completed for all household members)

Number of Household Members: _____

		Office Use Only MRN
1. Name: _____	**Date of Birth:** ____/____/____	_____
2. Name: _____	**Date of Birth:** ____/____/____	_____
3. Name: _____	**Date of Birth:** ____/____/____	_____
4. Name: _____	**Date of Birth:** ____/____/____	_____
5. Name: _____	**Date of Birth:** ____/____/____	_____
6. Name: _____	**Date of Birth:** ____/____/____	_____

*Additional family members may be added to the back of this form

ATTESTATION: *By signing below, I confirm that, as of today, the income sources listed include all of my household's income and all members listed are solely dependent on that income. If I provided an explanation to verify the income, I confirm that amount is truthful.*

Applicant Name (please print): _____

Applicant Signature: _____ **Date:** _____

Office use only

Total Annual Earnings: $_____ **Effective Dates:** _____ **thru** _____

Employee Signature: _____

Class A: _____ **Class B:** _____ **C lass C:** _____ **Class D:** _____ **Class E:** _____

Date Given: _____
Date Due: _____
Date Received: _____

MosaicMedical
Quality Care For All

Sliding Scale Program Patient Rights and Responsibilities

1. All patients may apply for the program whether or not you have insurance.
2. The household size is everyone in the house living off of the same financial resources. For children over 18, we need a copy of tax returns, current income documents or a signed statement.
3. Acceptance into the program is not guaranteed, your application will be reviewed and notification provided. If approved for the program, payment for services is due at the time of the visits.
4. We prefer patients turn in a complete application with all proof of income before receiving care. If that is not possible, applications are due within 10-business days. Applications received after 10-business days, will be considered effective the date they are received. Full payment for services not covered by the program will be expected.
5. Patients may re-apply for the program at any time. Each application will be documented and the 10-business day requirement will re-start.
6. Not all services provided in the clinic are covered under this program. Some examples of non-covered services are:
   a. Work related physicals or drug screens
   b. External testing services
7. The guarantor of this account is responsible for payments due for anyone listed on this application. If the account is sent to a collection agency, you are responsible for all collection agency account balances and fees.
8. We will not provide copies of the documents given with this application.
9. We may need additional information to verify your income or household size.
10. Any changes to a patient's income, living arrangements or insurance status must be shared with Mosaic Medical immediately. If Mosaic Medical is not notified of changes, patient may no longer be eligible for the program.

By signing below, I authorize Mosaic Medical to verify the information on the application and confirm that I have read and understand the Patient Rights and Responsibilities.

_____ _____

Signature of applicant Date

_____

Printed name of applicant

MosaicMedical
Quality Care For All

Sliding Scale Program
ATTESTATION

Only to be completed if proof of income is not provided or additional information needs to be provided. Please complete all sections that apply.

Applicant's Name: _____ Date: _____

If you have no income and are staying with friends/family, have them complete this section:

This letter verifies that _____ is presently unemployed and has no income.
Patient's name

S/he is residing with me and I am contributing $_____ per month to his/her support.

Contributor's Name: _____ Phone Number: _____

Contributor's Signature: _____ Date: _____

If you are employed and are unable to provide proof of income because you do not receive paycheck stubs, have your employer complete the following section:

_____, is currently employed at _____.
Employee's name *Name of company*

This employee's rate of pay is $_____ per month.

Employer Name: _____ Phone Number: _____

Employer Signature: _____ Date: _____

For all other situations complete this section:

I, _____, hereby declare that _____

_____

_____

_____

Signature: _____ Date: _____