

# ESCAMBIA COMMUNITY CLINICS, INC.

2200 North Palafox Street • Pensacola, Florida 32501 • (850) 436-4630 phone • (850) 436-2095 fax

*Dedicated To Meeting the Health Care Needs of our Community Since 1992*

## Affordable Health Care on a Sliding Fee Schedule

The following items are REQUIRED to process your application for the Sliding Fee Scale Program. Your application will NOT be processed without the requested information. Any information given to Escambia Community Clinics, Inc. will be kept confidential. If the information proves FRAUDULENT we reserve the right to cancel your Sliding Fee Scale status and bill you in full for all previous visits. Information needed:

1. A complete listing of household members, their ages and their relationship to patient.
2. Proof of HOUSEHOLD incomes. All incomes by ANY household member must be reported (employment wages, social security, pensions, child support, alimony, etc). We must have a minimum of three (3) current check stubs for every member in the household. If check stubs are not available you must provide a current tax form or notarized statement from the employer. Also requested is the last household bank statement including but not limited to checking and/or savings account and a utility bill from patient or supporter.
3. IF YOU HAVE NO INCOME - You must have proof of applying for Medicaid benefits or a copy of Food Stamp Certification and provide a NOTARIZED letter from the person(s) that support you.

### BEFORE SIGNING, please read the following:

1. Escambia Community Clinics, Inc. must be notified immediately if:
  - a. There is a change of income of any family member in the household.
  - b. Any member of the household obtains insurance of any kind.
  - c. There is a change of mailing address.

**You must pay your co-pay at the time of each visit.** If you are temporarily qualified for the sliding fee scale by one of our financial counselors and do not supply the required documentation (within 5 business days), you will be responsible for the remaining balance on your account. If payment is not received, Escambia Community Clinics, Inc. reserves the right to TERMINATE your eligibility in the Sliding Fee Scale Program and pursue further collection efforts.

I, \_\_\_\_\_ have read the above rules and agree to follow them.  
I also understand that if I do not comply with the rules set forth, my participation in the program will be terminated. *I understand that I am responsible for any past due balance owed to Escambia Community Clinics, Inc. prior to Sliding Fee Scale transition.*

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
FINANCIAL COUNSELOR'S SIGNATURE

\_\_\_\_\_  
DATE

# Escambia Community Clinics, Inc.

## Patient Registration Form

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

PHONE: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

SEX: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status: \_\_\_\_\_

African American  Caucasian  Asian  More than one race

Native Hawaiian/ Other Pacific Islander  American Indian/ Alaska Native

Are you Hispanic? Yes No ( please circle one )

SPOUSE'S NAME: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

Does Patient have any type of medical insurance?

\_\_\_\_\_ Medicaid \_\_\_\_\_ Share of Cost \_\_\_\_\_ Medicare \_\_\_\_\_ Other

Under penalty of law, I declare the information contained on this form to be true and correct and consent to the verification of this information by ECC. I also authorize ECC to release any information to any insurance company, the Florida Division of Family Services, Center for Medicare Services or any of their respective agencies that I may have designated as providing insurance in order to secure payment for any treatment provided by ECC.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

### Office Use Only

Patient Classification \_\_\_\_\_ Approved for \$5.00 Fee Status

\_\_\_\_\_ Approved for Sliding Fee Scale Percentage

Escambia Community Clinics, Inc.  
**CERTIFICATION OF LOW INCOME STATUS**  
 Income Assessment Worksheet

Please list income for all household family members. This does not include guests, roommates or non-dependent family members.

Source	Amount	Weekly	Bi-Weekly	Monthly	Annually
Salaries and Wages ( self )	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salaries and Wages ( spouse )	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pension Plan / IRA	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workman's Comp ( SSI )	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Security ( self / spouse )	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Security ( children )	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SSI ( supplemental security )	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Support / Alimony	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tip Income	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interest Income	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Military / Veterans Benefits	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public Assistance / Food Stamps	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stocks / CD's / Savings	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list all dependent family members by NAME, DATE OF BIRTH AND SOCIAL SECURITY NUMBER.  
 Please include yourself.

NAME	BIRTHDATE	SOCIAL SECURITY NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Escambia Community Clinics, Inc. reserves the right to inspect your tax return and/or wage statement for previous periods upon request. Eligibility will be updated on an annual basis. If there are any changes in your income status prior to your annual update, you should notify Escambia Community Clinics, Inc. immediately.

I hereby certify that the income and family composition information supplied in the above tables is true and correct to the best of my knowledge. I understand this document will be maintained in my permanent medical record and that falsification of information may constitute a federal offense.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

