Nebraska Urban Indian Medical Center

Sliding Fee Scale Application

Today's Date _____

Patient Name:_____ Patient SS#:_____ Date o Birth: _____

Responsible Party: _____ Relationship: _____ Responsible Party SS#: _____

Address: _____ Phone: _____
Street City, State Zip Code

Employer: _____
Name Address Ocupation Phone

How many hours do you work per week (on average)? _____ How much do you make per hour? _____

Does anyone else in the household work? YES NO If yes, who? _____

Where _____ How many hours per week? _____ How much does he/she make per hour? _____

Number of Adults: _____ Number of Children: _____ List everyone living in your household and their relationship to you:

NAME	RELATIONSHIP TO YOU	NAME	RELATIONSHIP TO YOU
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you, or anyone in the household, receive any of the following income:

Wages/ Tips/Compensation	YES	NO	Amount _____	ADC	YES	NO	Amount _____
Social Security/SSDI	YES	NO	Amount _____	Child Support	YES	NO	Amount _____
Unemployment	YES	NO	Amount _____	Food Stamps	YES	NO	Amount _____

List all agencies (including medical) you receive services from: _____
_____

Have you filled out an application for Medicaid? YES NO Were you denied Medicaid? YES NO
If YES please bring Medicaid denial letter.
Have you filled out an application for the Market Place for Insurance under Affordable Care Act? YES NO When _____
If NO, are you interested in learning about the Market Place? YES NO

Next Review: _____

Patient Name: _____ Chart # _____ Discount: _____

I understand that the Nebraska Urban Indian Medical Center will use this information to determine my payment for medical services provided to me. I affirm that the above information is correct to the best of my knowledge and hereby give NUIMC permission to research this information further if deemed necessary.

Signature of Responsible Party _____ Date _____

Sliding Fee Scale Agreement

When submitting a Sliding Fee Scale Application, I understand that I am responsible for submitting all information required from the Eligibility Determination Specialist on time. If there are any changes, for example increase or decrease in income, address, telephone, addition to the household, etc. I will submit information no more than 10 days after the change. If I do not comply with this Agreement I can become ineligible to receive any type of discount for office visits.

By signing this agreement you agree to submit proof of income within 10 days. If you do not submit proof of income you will be responsible for the full amount of the office visit/lab. Please submit proof of income to the address below.

Signature of Responsible Party _____ Date _____

Nebraska Urban Indian Medical Center
2331 Fairfield Street
Lincoln, NE 68521

Office Use Only
ID:

Proof of income:

Proof of residence:

Tax Return 20__

Other agencies:

Notice given via: verbal mail

Signature of NUIMC Representative _____ Date _____

Updated 5/20/14 am