APPENDIX I: 2020 Patient Information Worksheet/Application

Premier Health Network: Sliding Fee/Discount Patient Information Worksheet

It is the policy of Premier Health Network to provide essential services regardless of the patient's ability to pay. Premier Health Network offers discounts based on family size and annual income.

Please complete the following information and email it to premiercarechicago@gmail.com. Premier Health Network may use a third party (health navigation organization) to facilitate the qualification process for sliding fee/discount to determine if you or members of your family are eligible for a discount.

If you qualify for the sliding fee/discount program it only applies to services received at Premier Health Network; you will need to seek financial support separately for external services, medical equipment, reference laboratory testing, pharmaceuticals, hospital services, consulting services by specialists, and other services not rendered by Premier Health Network.

You must complete this form every 12-months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD:			**PLACE OF EMPLOYMENT:**	
STREET	**CITY**	**STATE**	**ZIP**	**PHONE**

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension, or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income:				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (printed):	
Signature:	
Date:	

OFFICE USE ONLY

~~**Patient Name:**~~	
Approved Discount:	
Approved by:	
Date Approved:	

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		