HONOR CARES
DISCOUNT FEE PROGRAM APPLICATION
INCOME AND FAMILY SIZE CERTIFICATION

Head of Household			Home/Cell Phone Number
Street	**City**	**State**	**Zip**
Do you currently have health insurance? ☐ YES ☐ NO			**Applicant's Date of Birth**

For Each Category Below, Enter Number of Family Members In Household	Number
Adults (Do not include your parents, grandparents, aunts, uncles, friends, roommates, children over 18)	
Unmarried Children (full/half/step) under age 19 (Do not include foster children)	
Unborn child of any of above family members	
Total Family Members	
Homeless Individual ☐ YES ☐ NO Adolescent (11-17 years old) ☐ YES ☐ NO	
Homeless individuals, adolescents and children in foster care are considered a family of one (1).	

Annual Household Income

Source	Self	Spouse	Other	Monthly Total
Wages, salaries, tips (monthly)				
Social Security				
Pension				
VA Benefits				
Alimony, child support (monthly)				
Self-employment (monthly)				
Other income (monthly)				
Total Monthly Income				**$**

List your spouse and all dependents who are eligible for Honor Cares-Discount Fee Program

Name	Date of Birth	Name	Date of Birth
Spouse		**Dependent**	
Dependent		**Dependent**	
Dependent		**Dependent**	
Dependent		**Dependent**	

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Patients will not be denied services (including adolescent confidential services) because of their inability to pay, including any outstanding balances from co-pays and deductibles.

☐ I confirm that the above is truthful and accurate. I agree to inform Honor Community Health of any changes in my income. Failure to provide truthful, accurate and/or timely information may result in loss of funding for sliding fee scale privileges.

☐ I refuse to apply for the Honor Cares Discount Fee Program.

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept in strict confidence.

You must verify your income at least every year.

Patient Signature **Date**

For internal use only:

Honor Cares Program Discount Amount

☐ This patient **qualifies** for the Honor Cares sliding fee program based on family size and household income reported.
☐ This patient **does not qualify** for the Honor Cares sliding fee program.

Category Slide:
(Circle one below)

	A	B	C	D
Medical	$15	$25	$35	$45
Behavioral Health	$5	$6	$7	$8
Dental- Preventative Services	$35	75%/min $40	50%/min $45	25%/min $50
Dental- Minor Restorative	$55	75%/ min $60	50%/ min $65	25%/ min $70
Dental- Major Restorative	$65	75%/ min $70	50%/ min 75	25%/ min 80
*Does not include dental lab fees and medical device/supply costs.				
Effective Date: Expiration Date: Approved by:				