



HONOR CARES DISCOUNT PROGRAM APPLICATION

All information is confidential and used for internal purposes only.

At Honor Community Health, we provide healthcare services to everyone, regardless of your ability to pay. We also offer a discount based on your household size and income. If you qualify, the discount will be applied to services at Honor, including lab tests. **Major dental services are not included in the discount program*

To continue participating in the discount program, you are required to complete a new application every year and provide proof of your income. This helps us make sure we are giving you the right discount you are getting the right benefits. Acceptable Proof of Income documents can be:

- **Paycheck stubs or direct deposit statements**
- **Disability payments (W2, check stubs)**
- **Tax documents (Tax return, W2, 1099)**
- **SSI Declaration page (SSA109)**

Complete the following information, even if you have insurance.

***You may be eligible for a discount even if you have insurance.*

1	Household Size: <i>How many people live with you that share expenses?</i>	
Household Member	Number	
You	1	
Spouse or Partner		
Dependent Children		
Other Dependents		



2	Household Income: <i>What is your income before taxes and deductions? If you or a household member have <u>no income</u>, write \$0.</i>		
Household Member	Income	How are you paid? Check ONE	
You	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
Spouse or Partner	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
Dependent Children	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
Other Dependents	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	

Check only ONE:

I **AGREE** to apply for the Honor Cares Discount program and confirm that the information above is true and correct. I agree to tell Honor Community Health about any changes in my income. If I do not give true, correct, or timely information, I will lose my discount.

OR

I **DECLINE** to apply for the Honor Cares Discount Program.

PRINT Name of Patient _____ or Patient's Legal Guardian _____ Patient's Date of Birth _____

SIGNATURE of Patient _____ or Patient's Legal Guardian _____ Today's Date _____

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OFFICE STAFF ONLY

Was proof of income provided? Yes No

-----> If so, does it match what patient documented above? Yes No N/A

Document the amount entered in Nextgen: \$ _____

Signature of Employee (*who reviewed and entered information*) _____ **Today's Date** _____