# EXCEL PEDIATRICS & FAMILY CARE

## Family Assistance Plan Application

NAME OF HEAD OF HOUSEHOLD		PLACE OF EMPLOYMENT			
STREET	СІТУ	STATE	ZIP	PHONE	
HEALTH INSURANCE PLAN			SOCIAL SECURITY NUMBER		
Please list spouse and	dependents under age 18				

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

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				

Source	Self	Spouse	Other	Total
Alimony, child support, military family allotments				
Income from business self employment, and dependent	s	•		
Rent, interest, dividend, and other income			*******************	
Total Income			***********************	**********************
Certify that the family size and income information shown information verifying income may be required before a dis Name (Print)  Signature  Office Use Only  Patient Name  Date of Service		Copies of tax r	eturns, pay stu	ibs, and oth
Verification Checklist (attach copies)	YES		NO	
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other				
Income: Prior year tax return, three most recent pay stubs, or other				
Insurance: Insurance card(s)				

### pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or a member of your family are eligible for a discount. The discount will apply to all services received at this clinic, but not those services which are purchased from

Number of related persons living in your household:

Medicaid: Application made or evidence of rejection

Services Covered and Excluded

**Excel Pediatrics and Family Care** 265 Citrus Tower Blvd #102 Clermont, FL 34711

Household Member

Dependent Children

under age 18

Patient Name

Date of Service

Self

Spouse

Discounted/ Sliding Fee Application

Household Income (complete one column)

Annual

Monthly

Discount

Approved by

Bi-Weekly

It is the policy of Excel Pediatrics and Family Care to provide essential services regardless of the patients ability to

outside, including reference laboratory testing, drug, and x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This for must be completed for each visit. Please inquire at the front desk if you have any questions.

	an's payments,
	s, pay stubs, and other
Date	
y	ecurity, disability, pensions, annuities, veters yment, and public aid.  ove is correct. Copies of tax returns t is approved.  Date

Eligibility is based on family size and household income according to the most recent US Department of Health & Human Services Federal Poverty Guidelines 2012. This service will be available only if there is no medical insurance. Sliding scale services are available for all individuals and families with an annual income below 200 percent of the poverty guidelines.

Excel Pediatrics Guidelines for determining eligibility for sliding scale

Other types of services/ additional charges include: **Immunizations** Urinalysis

The sliding scale fee amount due for an office visit only the charge can and will be more depending on other

Blood work/ Rapid Strep/ Flu. Any kind of workup Nebulizer treatments Guidelines for sliding scale fee:

The sliding scale fee will not be waived at any time for any person under any circumstance.

services provided, and or visit type/code. Patients will be responsible for any additional charges.

- Income of parents and children under 18
- Income will be verified semi-annually Anyone requesting a discount will be verified, and will be applied in a non-discriminatory manner
- Only the office manager or the Dr. may approve discounted fees At each visit the staff will ask if anything has changed Change in income will cause re-evaluation
- Persons with approved discounts will have an alert in their chart
- No patient will be denied services due to inability to pay
- Every patient's privacy is protected
- Patients at or below poverty level are charged a nominal fee or no charge at all This does not apply to copayments or deductibles, Medicaid share of cost, suboxone program, or the
- weight loss program. Same day visits will require payment up front if not approved already. There will be no retroactive effective date
- A separate appointment for determining eligibility is required. Application process may take up to 3 business days to process. Must have the following information with you at time of appointment:
  - Proof of current address (such as drivers license, state ID card, pay check stub, phone bill, electric bill, or lease) Most recent federal tax form (1040 form)

Assistance for Needy Families, Free or Reduced lunch program, or any other public assistance.

The last 2 current paystubs (If no pay stub you may bring the following: unemployment stubs, or letter from the company on company letter head, or a notarized letter from current employer) Awards or benefit letter for food stamps, Social Security Income(disability), workers comp, Temporary

Proof of identification (such as driver license, state ID card, passport, or bank card with photograph.)