BARAGA COUNTY MEMORIAL HOSPITAL (BCMH)
AND
BCMH PHYSICIAN GROUP RURAL HEALTH CLINIC (RHC)
CARES PROGRAM
DISCOUNT SLIDING FEE SCALE APPLICATION

It is the policy of Baraga County Memorial Hospital and the BCMH Physician Group RHC to provide essential services, regardless of the patient's ability to pay. Discounts are offered, depending upon household income and size. Once the following information has been obtained, we will determine if you or members of your family are eligible for a discount. The discount will apply to all eligible services received at the hospital or clinic ***but not those services which are purchased from outside the hospital or clinic.*** ***E***ligibility, if approved, is good for one year. If there is a change in your insurance, household and/or financial situation, we ask that you provide us with updated information, within 5 business days, so your situation may be re-evaluated. A $10 minimum payment is required and is collected upfront.

Date of Application: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (906) _____ Cell Phone: _____ E-mail address: _____

Social Security Number: _____ Date of Birth: _____

Number of family members living in your household: _____

Total Household Income*					
Household Member	**Date of Birth**	**Income (Complete one column)**			
		Annual	**Monthly**	**Weekly**	**Other**
Self					
Spouse/Other					
Dependents					
TOTAL					

***Note:** Include income from all members in household (regardless of whether they are included under this application, and income from all sources including gross wages, tips, social security, disability, workman's compensation, pensions, annuities, veteran payments, net business or self-employment, annuities, child support, military, unemployment, public aid and other. You **must** supply proof of income to qualify for a discount. Proof required is your last check stub; a statement from your employer, if applicable; and your current tax return (W-2 only if you don't file taxes).

Have you applied for medical assistance which may cover these services? □ Yes □ No
(You must provide evidence of application from Department or Human Services to qualify for a discount.)

Do you have health insurance? □ Yes □ No Are you eligible for insurance? □ Yes □ No

Have you been granted an exemption from Healthcare.gov? □ Yes □ No
(You must provide proof you applied through Healthcare.gov to qualify for a discount.)

I affirm that this statement of family income and size is true and accurate to the best of my knowledge, and that all statements made by me in this application are true. I understand that this information is subject to verification (which may require a credit check) by Baraga County Memorial Hospital/BCMH Physician Group RHC and is subject to review by federal and/or state enforcement agencies and others as required.

I also affirm that I am aware that I must report any changes in my family or household income status that could affect my eligibility for this program within five (5) working days of the change in status. I understand that changes that must be reported could include any of the following:

- An increase or decrease in household gross income for any reason
- Change in family size living in household
- Eligibility for medical assistance
- Eligibility for Social Security benefits
- A work-related injury covered by Worker's Compensation
- Eligibility for insurance benefits
- Any other circumstances which may result in medical coverage by another party.

Signature: _____ Date: _____

Office Use Only

Date application received: _____ Received by : _____

Eligibility: □ Yes □ No

Assessed by : _____ Date: _____

Discount amount: _____ Patient notified on: _____

Note: This program can cover services up to 60 days prior to the date you turn in your application.