HOMETOWN CARE OF NORTH MS

SLIDING FEE PROGRAM

READ THIS PAGE

Please provide proof of all household income **(adults and children)** in with your application **before** it is returned to us. Without the income proof, your application **WILL NOT** be processed, and it will be sent back to you resulting in approval delay. Please also include your full legal name (as it appears on your birth certificate), date of birth, and SSN.

Ways to provide income proof:

If anyone in your household draws Social Security or SSI check(s) or VA check, you can send one of the following, per Hometown Care of North MS, Inc. Policy:

- ✓ A copy of your check before cashing, and mail the copy in with your application.
- ✓ If you have direct deposit, then provide a copy of the **2 previous month's** bank statements showing **US TREASURY** and the amount deposited. ***Please Note:*** *If you do not include bank statements for the* ***2 previous months****, then your application* ***will not*** *be processed.*
- ✓ The award letter you received from the Social Security Office in December showing what you will receive each month the following year. ***Please Note:*** *The 1099 that you receive for your income taxes* ***does not qualify*** *as income proof.*

All patients are required to pay deductibles, copays, coinsurance, and any previous outstanding balances **before being seen**. If you are unable to pay, **please call before your visit to set up payment arrangements.**

IF you draw a pension check: Please send a recent stub for proof of the amount. If you receive unemployment benefits, please provide a copy of your award letter.

IF you work and are paid weekly: 4 recent check stubs. **IF you are paid biweekly** – then 2 recent check stubs. **IF you are paid monthly** – 1 recent check stub.

IF you do not have the check stubs or are paid in cash: Please have your employer/payroll department fill out the ***Verification of Earnings Form*** at the bottom of the last page of the application.

IF you are self-employed and were self-employed last year: Please provide ***Page 1, Page 2, and Schedule C (Profit/Loss page)*** of your previous year's tax return for proof of income.

If none of the above applies to you and someone is helping you with bills and expenses, have them fill out the support form as your proof of income.

Please be sure to sign the application (first page, bottom left corner). Application invalid without a signature.

Submit your application, along with all required documentation, using any one of these methods:

Contact our office with any questions at (662) 276-5065 or visit website www.hometowncarenms.com

HOMETOWN CARE OF NORTH MS

Sliding Fee Discount Program Application • Head of Household Information

Name: _____ Birth Date: _____/_____/_____
Last First Middle

Address: _____ Social Security # _____-_____-_____
Number & Street/PO Box

_____ Phone: (_____) _____-_____
City State Zip

Race: ❑ White ❑ Black ❑ Multi-racial Latino/Hispanic Descent? ❑ Yes ❑ No Sex: ❑ Male ❑ Female

Marital Status	**Occupation**	**Employment Status**	**Referral Source**
❑ Never Married	❑ Homemaker	❑ Full Time	❑ Program Referral
❑ Married	❑ S. Farm Worker	❑ Part Time	❑ Welfare Agency
❑ Separated	❑ M. Farm Worker	❑ Student	❑ Family/Friend
❑ Divorced	❑ Military	❑ Disabled	❑ Hospital
❑ Widowed	❑ Other Employment	❑ Retired	❑ Advertisement
❑ Common Law	❑ Unemployed	❑ Unemployed	❑ Other

Employer: _____ **Employer Telephone:** (_____) _____-_____

Employer Address: _____
Street City State Zip

FAMILY MEMBERS

(LIST ALL FAMILY MEMBERS LIVING IN YOUR HOUSE RELATED BY BLOOD, BIRTH, OR MARRIAGE)

Name	Race	Sex	Date of Birth	Relationship	Employment	Social Security #	Insurance?
		☐ M ☐ F	/ /			- -	☐ Yes ☐ No
		☐ M ☐ F	/ /			- -	☐ Yes ☐ No
		☐ M ☐ F	/ /			- -	☐ Yes ☐ No
		☐ M ☐ F	/ /			- -	☐ Yes ☐ No
		☐ M ☐ F	/ /			- -	☐ Yes ☐ No
		☐ M ☐ F	/ /			- -	☐ Yes ☐ No

PLEASE FILL IN THE COLUMN WITH YOUR GROSS AMOUNT WHICH APPLIES TO HOW YOU ARE PAID

	Per Hour	Weekly	Bi-weekly	Monthly	Bi-monthly	Other	TOTAL
Head of Household	$	$	$	$	$	$	$
Spouse	$	$	$	$	$	$	$
Other	$	$	$	$	$	$	$

PLEASE PROVIDE PROOF FOR ANY OF THE FOLLOWING YOU RECEIVE	
Self-employed Income	$
Social Security Retirement	$
Pensions	$
Veteran's Benefits	$
Workers Compensation	$
S.S.I. & Disability Insurance	$
Railroad Retirement	$
Unemployment Compensation	$
Welfare	$
Support or Alimony Payment	$
Rental Income	$
Interest Income	$
Total Household Income	$

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____/_____/_____

Office Use Only

Approval date: _____/_____/_____

Approved: _____

Sliding Fee Scale: _____%

HOMETOWN CARE OF NORTH MS

VERIFICATION OF EARNINGS FORM

Dear Employer:

An employee of your company has applied for the Sliding Fee Discount Program (financial assistance) at Hometown Care of North MS, Inc. Please complete this form and return it to the employee. Thank you for your cooperation.

Name of Employee: _____

Employee Address: _____
Number & Street/PO Box City State Zip

Social Security Number: _____ - _____ - _____

It is hereby certified that the individual named above is employed by the undersigned, and that the following wages and hours represent a normal rate of this individual.

Name of Employer: _____

Employer Address: _____
Number & Street/PO Box City State Zip

Number of hours employee works per week (average): _____

Average Gross Weekly Income: $_____

_____
Printed Name of Employer Representative **Signature** of Employer Representative

Employer Telephone Number: (_____) _____-_____

Does employee have health insurance coverage? ☐ Yes ☐ No

PERMISSION TO RELEASE WAGE/INSURANCE INFORMATION:

_____
Patient Signature Date

HOMETOWN CARE OF NORTH MS

SUPPORT FORM

Instructions to Person Helping Household:
Please check the box(es) that apply, fill in name(s) and date(s), then sign and give back to applicant.

To Whom It May Concern:

I, the undersigned, verify that I [☐ give ☐ loan] money to _____
(check one) (name of applicant)

to help with living expenses each month. In the month of _____, 20_____ I [☐ gave ☐ loaned]
(check one)

the amount of $_____.

Check all that apply:

☐ I [☐ gave ☐ loaned] this money directly to the named applicant to help pay household expenses.
(check one)

☐ I pay this money directly to the company(ies) to cover expenses for the named applicant's household.

☐ I will continue to do this each month.

☐ I will not continue to do this. I am only helping temporarily or until _____/_____/_____.

_____
PRINTED Name of Person Helping Household

Address of Person Helping Household:

_____
Number & Street/PO Box City State Zip

_____
SIGNATURE of Person Helping Household Date

Contact Number of Person Helping Household: (_____) _____-_____