HARMONY HEALTHCARE

Value Based Care Discount Application

Patient Information

Full Name: _____ DOB: _____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone: _____ Email _____

Annual Income: $ _____ Social Security No.: _____ Marital Status: _____

Do you have Health Insurance? YES ☐ NO ☐

NOTE: To comply with federal regulations, to give you a discount on our medical services, it is necessary for you to fill out this form, answer some personal questions, and provide proof of income. Your answers will be kept on file and in strict confidence. You must verify your income at least every 6-12 months. Please bring yearly income tax return, copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive as proof of family income. Only the family size and annual income will be used to determine your eligibility and calculate your discount.

☐ **I choose NOT to apply for the Value Based Care Discount.** Please sign and date here:

_____ _____

Signature Date

☐ **I choose to apply for the Value Based Care Discount.** The sliding fee scale is available for all patients, regardless of insurance status. If you have insurance, the sliding fee scale discount can be applied to charges not covered by insurance. Please complete the entire form to determine eligible discount.

Household Size

HOUSEHOLD MEMBERS	NAME	BIRTHDATE (MM/DD/YYYY)	RELATIONSHIP	HEALTH INSURANCE	CURRENT HARMONY PATIENT?
1					
2					
3					
4					
5					
6					

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Household Income

SOURCE OF INCOME	INCOME TYPE	FOR YOU	FOR SPOUSE/PARTNER	FOR OTHERS (INCLUDING CHILDREN)	SUB TOTAL
	Gross Wages, Salaries, Tips, etc	$	$	$	$
	Social Security & Pensions	$	$	$	$
	Annuity & Veteran Benefits	$	$	$	$
	Child Support & Alimony	$	$	$	$
	Self-Employment & Other	$	$	$	$
	Food Stamps & Public Assistance	$	$	$	$
	For "Other," please explain:				
				TOTAL	$

Disclaimer and Signature

BY SIGNING BELOW, I AGREE TO PROVIDE HARMONY HEALTHCARE ORLANDO, INC (DBA HARMONY HEALTHCARE, INC) WITH ACCEPTABLE PROOF OF INCOME FOR ALL PERSONS LISTED ABOVE. I UNDERSTAND THAT I WILL BE ASKED TO REAPPLY FOR THE VALUE BASED CARE DISCOUNT AT LEAST ONCE EVERY 6 MONTHS SO THE ORGANIZATION CAN MAINTAIN AN UPDATED APPLICATION ON FILE.

I CERTIFY THAT THE HOUSEHOLD SIZE AND INCOME INFORMATION SHOWN ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF ANY OF THE INFORMATION I HAVE SUBMITTED IS DETERMINED TO BE FALSE, I MAY NO LONGER BE ELIGIBLE FOR THE VALUE BASED CARE DISCOUNT. SHOULD THIS OCCUR, I MAY BE RESPONSIBLE FOR ANY OUT-OF-POCKET EXPENSES. I GIVE MY CONSENT TO RELEASE ANY AND ALL INFORMATION FROM WHATEVER SOURCE NEEDED TO VERIFY THE INFORMATION I HAVE GIVEN.

Signature: _____ Date: _____

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FOR OFFICE USE ONLY

Verification Checklist	Yes	No
Driver's license, or Birth certificate, or Social Security Card, or Other		
Prior year tax return, or Two most recent paystubs (must equal at least 4 weeks for payroll), or W-2 or 1099, or Other		
Insurance Card (if applicable)		
Medicaid Card or evidence of rejection		
Medicare Card		
Letter of: Social Security Benefit Verification, Unemployment Award, Pension Benefit, Self-Employment, or Other		
Letter of Financial Support, Hardship, or Homelessness		

VBC Status (Check one):

- ☐ A- 20% fee
- ☐ B- 40% fee
- ☐ C- 60% fee
- ☐ D- 80% fee
- ☐ E- Full Discount (Nominal Fee Only)
- ☐ F- Patient is ineligible.

Approved By: _____ _____

Signature & Print Name **Date**

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