Upstate Family Health Center, Inc.

1001 Noyes Street, Utica, NY 13502
Phone: 315-624-9470 **Fax:** 315-624-9480

Community Discount Program (SFDP) Document Checklist

Patients who are unable to pay for services at any of the Upstate Family Health Center, Inc. (UFHC), may qualify for our Community Discount Program (SFDP). The SFDP will cover all or a portion of the cost of care you receive. The amount of financial assistance received is based on income and household size following the Federal Poverty Guidelines.

To be considered for this program you must provide one of the following to satisfy the proof of income requirement:

- Most recent income tax return with W-2(s) and/or 1099
- Most recent 2 pay stubs Earnings record from ssi.gov
- Proof of social security income, if applicable
- Proof of alimony, child support, unemployment, pension etc
- Other earning documents (provide to staff to be evaluated)

If you are unable to provide an acceptable form of proof of income, you may sign a self-attestation statement and are requested to provide one of the following documents in support of this statement:

- Verification letter, if receiving foodstamps Proof of family planning only, Medicaid Proof of Emergency Services only, Medicaid
- If you receive no income and are being supported by relatives or friends, a letter explaining those arrangements is requested. The letter must be signed by person(s) lending assistance.

Please return your proof of income documentation to UFHC, Inc. location, or mail it to:

Upstate Family Health Center, Inc.
1001 Noyes Street, Utica, NY 13502
Attention: Billing Manager

Upstate Family Health Center, Inc.

1001 Noyes Street, Utica, NY 13502
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Community Discount Program (SFDP) Application Instructions

Patients who are unable to pay for services at any of the Upstate Family Health Center, Inc. (UFHC), may qualify for our Community Discount Program (SFDP). The SFDP will cover all or a portion of the cost of care you receive. The amount of financial assistance received is based on income and household size following the Federal Poverty Guidelines.

To be considered for this program you must complete the attached application and provide one of the following to satisfy the proof of income requirement:

- Most recent income tax return with W-2(s) and/or 1099
- Most recent 2 pay stubs
- Earnings record from ssi.gov
- Proof of social security income, if applicable
- Proof of alimony, child support, unemployment, pension, etc.
- Other earning documents (provide to staff to be evaluated)

If you are unable to provide an acceptable form of proof of income, you may sign a self-attestation statement and are requested to provide one of the following documents in support of this statement:

- Verification letter, if receiving food stamps
- Proof of family planning only, Medicaid
- Proof of Emergency Services only, Medicaid
- If you receive no income and are being supported by relatives or friends, a letter explaining those arrangements is requested. The letter must be signed by person(s) lending assistance.

Once your application is completed, please return it and your proof of income documentation to UFHC, Inc. location, or mail it to:

Upstate Family Health Center, Inc.
1001 Noyes Street, Utica, NY 13502
Attention: Billing Manager

Upstate Family Health Center, Inc. will review your application to determine the level of assistance for which you are eligible. Once a decision is made, you will be notified of approval or denial of the Community Discount Program (SFDP). If approved, the level of financial assistance received will be based on household size and income on the Federal Poverty Guidelines.

If approved, this application will be good for one year. The discounted amount will be valid at Upstate Family Health Center, Inc. (UFHC). You will need to inform UFHC if there are any changes in your financial situation during the year that may impact your eligibility for this program. If you need any assistance with the application, please contact us in person or by phone at (315) 624-9470.

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Discount Program Application

Patient Information:

Name:____DOB _____________
(Last) (First) (MI) (MM/DD/YYYY)

Address:____
(Street/Apt Number) (City) (State) (ip)

Telephone Number: ( ) ( )
(Home) (Cell)

Parent/Guardian Information 1:

Name:____DOB:____/____/_____
(Last) (First) (MI) (MM/DD/YYYY)

Address:____
(Street/Apt Number) (City) (State) (ip)

Relationship to Patient:______________Telephone Number: (__)__________(___)__________
(Home) (Cell)

Parent/Guardian Information 2:

Name:____DOB:____/____/_____
(Last) (First) (MI) (MM/DD/YYYY)

Address:____
(Street/Apt Number) (City) (State) (ip)

Relationship to Patient:______________Telephone Number: (__)__________(___)__________
(Home) (Cell)

Household and Income (List all people living in the household, including yourself):

	Name	Relationship	Age	Annual Income	Source
1					
2					
3					
4					
5					

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Self-Attestation Statement: I am unable to provide any proof of income as described above and have discussed this with staff. I agree to provide requested documents to support this statement. I understand this information will be used to determine my eligibility for the Community Discount Program (SFDP). By signing this section, I am stating that I am providing truthful, to the best of my knowledge, information, and I self-attest to the income (or lack of income) stated in the household/income section above.

Signature of Patient/Guardian:____________________________Date signed:_________________

Witness:______________________________Printed Name: _______________________________

I hereby request that Upstate Family Health Center, Inc. to determine my eligibility for Community Discount Program (SFDP) services. I hereby attest that I am not covered by any form of prescription insurance, nor am I covered by any form of government-sponsored health insurance, including Medicare, Medicaid, VA benefits, or other coverage.

I understand that the information, which I submit concerning my annual income and household/family size, is subject to verification by this organization and subject to review by state and/or federal enforcement agencies and others as required. I understand that the information given within this document is for the purpose of determining eligibility for the Community Discount Program (SFDP) and that false or incomplete information will result in my disqualification for assistance.

If my financial situation changes in the upcoming year, I will report these changes to Upstate Family Health Center, Inc. immediately.

Print Patient Name: ____

Signature of Patient/Guardian:____________________________Date signed:_________________

Witness:______________________________Printed Name: _______________________________

For Finance & Accounting Use Only:

Reviewed by:____Title:____________________Date:_________________

☐ Approved ☐ Denied Reason for Denial:____________________________________

Percentage: % _________ UFHC Slide:____________________

Self-Declaration of Income

Name:____________________________________ **Date of Birth:** ________________________

1. **Please indicate the reason why you are unable to provide proof of income:**

   ☐ I have no income.
   - If you have no income, skip to question 5.

   ☐ My employer pays me in cash.
   ☐ I do not receive pay checks.
   ☐ I do not receive pay stubs.
   ☐ My employer will not provide a letter

2. **Where do you work or what type of work do you do?** ____________________________________

3. **How often are you paid?**

   ☐ Weekly
   ☐ Every Other Week
   ☐ Monthly
   ☐ Twice a Month
   ☐ Other (please explain) ____

4. **How much money do you receive each time you are paid?** _________________________________

5. **Please read the following statement and sign below.**
   I certify that I have no other way to document my income and that all the above information is true and correct. I understand that this information is to be used to determine eligibility for the patient assistance programs at White House Clinics. This documentation will become part of the medical record for all patients identified as family members in the household on the sliding fee application.

Patient Signature

____

Internal Use Only (should be completed by UFHC employee who completes financial statement with patient)

I certify that I asked the applicant/recipient about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation.

______________________________ ____

Employee Signature **Printed Name of UFHC Employee** **Date**