Laura J. Hoss, MD **Eric M. Jump, DO** **Cynthia D. Skelly, MD**
Paula B. Phillips-Hastay, ARNP **Tiffany D. James, ARNP**

Origination Date _____

Kids Care Pediatrics Sliding Fee Discount Application

Kids Care Pediatrics provides much needed healthcare services to the children of Putnam County and northeast Florida. Sometimes children's families have financial difficulties which may affect their decision as to whether or not they seek care for their children.

It's Kids Care Pediatrics policy to provide our services regardless of the patient's family's ability to pay.

All efforts to secure third party coverage/payment for their children's healthcare must be exhausted before our policy takes effect. Specifically, if the applicant's children appear to be eligible for Medicaid, a written denial of coverage by Medicaid is required whereby the denial is not for failure to provide information requested.

Discounts are offered based upon *Household Income* & *Family Size.* Please complete the application and return it, along with all required documentation, to your *Patient Account Representative* who will then determine whether your family is eligible for a discount.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	**CITY**	**STATE**	**ZIPCODE**	**PHONE**

Please list spouse and dependents under age 18

Name	DOB	Name	DOB
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment Compensation, Worker's Compensation, Social Security, Supplemental Security Income, public assistance, Veterans' Payments, Survivor Benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources				
Total Income				

Note: Copies of tax returns, pay stubs or other information verifying income will be required before a discount is approved.

I certify that the Family Size and Annual Income information shown above is correct.

Name (Print)	Relationship To Patient(s)
Signature	Date

Office Use Only-Verification Checklist	Yes	No
Identification/Address: Driver's License, Utility Bill, Employment ID, or other		
Income: Prior Year Tax Return, three most recent pay stubs, or other		
Insurance: Insurance Cards		

Medicaid Evidence of Rejection	Yes	No	Medicaid Application Made	Yes	No

Office Use Only

Discount?	Yes ____ %, $___, No
Decision Date	
PAR Signature	

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