Discount Program Application

We are here for you! Our discount program is available to all eligible patients without regard to age, gender, race, sexual orientation, creed, religion, disability, or national origin. We ask that you complete this application as accurately as possible. Eligibility for the discount program is determined using two criteria:

(1) FAMILY SIZE
Financially dependent persons currently living with you including the following: spouse/partner, children from birth/marriage/adoption, and other persons living in your home related to you by birth/marriage/adoption who are considered your dependent(s). An individual is considered a family size of one.

Name________________________________ DOB ________ Relationship __________ MCC Patient? **YES NO**

Name________________________________ DOB ________ Relationship __________ MCC Patient? **YES NO**

Name________________________________ DOB ________ Relationship __________ MCC Patient? **YES NO**

Name________________________________ DOB ________ Relationship __________ MCC Patient? **YES NO**

Name________________________________ DOB ________ Relationship __________ MCC Patient? **YES NO**

Name________________________________ DOB ________ Relationship __________ MCC Patient? **YES NO**

Name________________________________ DOB ________ Relationship __________ MCC Patient? **YES NO**

(2) INCOME (Please Provide Proof of Income)
All earnings for your family. Earnings include wages, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, alimony, and cash assistance from outside the household. Income does not include non-cash assistance.

Primary Applicant Income: $____________________ ☐ Weekly ☐ Monthly ☐ Yearly

Income for other Adults (over 18) in family: $____________________ ☐ Weekly ☐ Monthly ☐ Yearly

Total Family Income: $____________________ ☐ Weekly ☐ Monthly ☐ Yearly

I understand that if the information I provide is found to be inaccurate, Minnesota Community Care reserves the right to bill me for the entire cost of care at 100% of charges.

$____________________ ____ ______________

My/Our Total Monthly Income **Signature of Patient/Legal Representative/Parent/Legal Guardian/ Authorized Representative** **Today's Date**

Minnesota Community Care employee completes area below the line

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Completed by:	Eff Date: Term Date:	Total Family Monthly Income: Household Size:	☐ Medical/Pharmacy ☐ Ryan White ☐ Dental ☐ Homeless ☐ HealthStart	☐ Cat A ☐ Cat B ☐ Cat C ☐ Cat D ☐ OVER INCOME	☐ POI or Attestation Letter provided ☐ POI or Attestation Letter Due Date:

Place Label Here

Discount Programs

Thank you for choosing Minnesota Community Care for your health needs. We are able to provide discounted services as a non-profit community health center using very limited grant funding. The average cost of a visit is $270. We ask you for a payment that is significantly below our actual cost. Your payment allows us to continue operating and serve others in the community.

Eligibility for Minnesota Community Care's discount program is based on income and family size, using the Federal Poverty Guidelines (FPG).

Based on your provided income and family/household size, the patient(s) on this application are assigned to sliding fee category __________ under the ___________________________________ program. A nominal fee is due on the date of service for each appointment, which is applied to the patient's overall responsibility as indicated below.

	Medical	**Dental**	**HealthStart**	**Ryan White**	**Homeless**
Services Covered	Medical and Behavioral Health	Dental ***(selected services only)***	Medical and Behavioral Health provided in school-based clinics	Medical, chiropractic, pharmacy services related to HIV	Medical, Dental and Behavioral Health
Applies to	Each eligible family member listed on the application	Each eligible family member listed on the application	Only the patient	Only the patient	Only the patient
Nominal Fee due on DOS	$40 all categories	$50 all categories	$40 all categories	Cat A= $0 $40 all other categories	$0
Patient overall responsibility	**Cat A**: $40 **Cat B**: 25% of total charges **Cat C**: 50% of total charges **Cat D**: 75% of total charges	**Cat A**: $50 **Cat B**: 25% of total charges **Cat C**: 50% of total charges **Cat D**: 75% of total charges	**Cat A**: $40 **Cat B**: 25% of total charges **Cat C**: 50% of total charges **Cat D**: 75% of total charges	**Cat A**: $0 **Cat B**: $40 **Cat C**: $40 **Cat D**: $40	$0
Duration of discount	6 months	6 months	6 months	6 months	6 months

Patients above 200% of the FPG are not eligible for the Medical, Dental or HealthStart sliding fee discount program.
Patients above 400% of the FPG are not eligible for the Ryan White discount program.
**Certain services are not covered by any MCC discount program including, but not limited to INS physicals and circumcisions.*

This application is valid for 6 months after the date approved. The patient must re-apply at least every 6 months. If the patient's financial situation changes significantly (e.g., loss of employment, obtain employment, change in household, etc.) and/or receives insurance coverage after this application is approved but before 6 months has passed, the patient must inform Minnesota Community Care and has the option to reapply for eligibility for the Sliding Fee Discount Program.

Patients who do not have third-party insurance and are not eligible for a discount program (or refuse to apply for a discount program) will be required to pay $250 before they receive medical or dental services.

For questions regarding your bill or if you are interested in a payment plan, contact our billing department at
651-602-7500