**Clínicas Dr. Héctor Valencia**

**2020 Patient Information Worksheet/Application**

Dr. Héctor Valencia Pediatric Clinics: Sliding Fee/Discount Patient Information Worksheet It is the policy of Dr. Héctor Valencia Pediatric Clinics to provide essential services regardless of the patient’s ability to pay. Dr. Héctor Valencia Pediatric Clinics offers discounts based on family size and annual income.Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

Dr. Héctor Valencia Pediatric Clinics utilizes a health navigation team (Care Advisors) to facilitate the qualification process for sliding fee/discount. The discount will apply to all services received at this practice, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, and x- ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

|  |  |
| --- | --- |
| **NAME OF HEAD OF HOUSEHOLD:** | **PLACE OF EMPLOYMENT:** |
|  |  |
| **STREET** | **CITY** | **STATE** | **ZIP** | **PHONE** |
|  |  |  |  |  |

**PLEASE LIST SPOUSE AND DEPENDENTS UNDER AGE 18.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Name** | **Date of Birth** |
| 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, workers' 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 may be required before a discount is approved.

**I certify that the family size and income information shown above is correct.**

|  |  |
| --- | --- |
| **Name (printed):** |  |
| **Signature:** |  |
| **Date:** |  |

 **OFFICIAL USE ONLY**

|  |  |
| --- | --- |
| **Patient Name:** |  |
| **Approved Discount:** |  |
| **Approved by:** |  |
| **Date Approved:** |  |

|  |  |  |
| --- | --- | --- |
| **Verification Checklist** | **Yes** | **No** |
| Identification/Address: Driver’s license, utility bill, employment ID, or other |  |  |
| Income: Prior year tax return, 2-4 paystubs depending on you payment method  (weekly or biweekly), or other |  |  |
| Insurance: Insurance Cards |  |  |

If you need financial assistance or help qualifying for insurance, please contact Care Advisors:

**Care Advisors**

 **( 718 ) 779- 5855**