RVPCS SFDP APPROVAL LETTER

This verifies approval of _____ _____
Last Name First Name MI DOB

For discounted services through the clinics sliding fee program. Applicant is qualified as Level _____

Service/ Class	% of FPG	Nominal Fee/Co-Pay Medical/Behavioral	Nominal Fee/Co-Pay Lab Only Visit (In House)	Nominal Fee/Co-Pay Dental
A	Below 100%	$20	$0	50%
B	101% to 125%	$25	$5	40%
C	126% to 150%	$35	$8	35%
D	151% to 175%	$45	$10	30%
E	176% to 200%	$50	$12	25%

Eligibility period is from _____ to _____.

Co-pays are payable on the date of service. Non-discounted medical services include lab work sent to an outside reference lab, referrals for specialized x-rays or diagnostic services, emergency room services, hospitalizations, and those services deemed medically unnecessary by the provider staff. **You will be responsible for charges incurred for services not available on site**. Non-covered dental services include crowns, bridges, and dentures. Prepaid arrangements may be available after consultation with the dentist.

Household members approved for this period:

Relationship	Last Name	First Name	MI	DOB	Insurance

I have been fully informed and understand the discount fee program of RVPCS. I further understand my financial responsibility under this program for services provided to me and other qualified household members.

_____ _____
Applicant's Signature Date

Office Use Only: v.05/2019 Insurance_____ Approved by:_____

9755 W. State Hwy. 22, P.O. Box 130, Ratcliff, AR 72951 ♦ Phone (479) 431-2050 ♦ Fax (479) 431-2051
4900 Kelley Highway, Fort Smith, AR 72904 ♦ Phone (479) 785-5700 ♦ Fax (479) 785-5708
3202 North 6th Street, Fort Smith, AR 72904 ♦ Phone (479) 783-3900 ♦ Fax (479) 783-3905
9616 Rogers Avenue, Fort Smith, AR 72903 ♦ Phone (479) 434-4747 ♦ Fax (479) 434-5561
421 North Main Street, Mulberry, AR 72947 ♦ Phone (479) 997-1484 ♦ Fax (479) 997-1494
4 Hwy 71, Mountainburg, AR 72946 ♦ Phone (479) 369-2091 ♦ Fax (479) 369-4119
635 Childers Street, Lamar, AR, 72846 ♦ Phone (479) 668-4881 ♦ Fax (479) 668-4909
2074 Rice Road, Waldron, AR 72958 ♦ Phone (479) 668-4700 ♦ Fax (479) 668-0200
708 West Main Street, Clarksville, AR 72830 ♦ Phone (479) 668-3282 ♦ Fax (479) 668-3284

RVPCS SLIDING FEE DISCOUNT PROGRAM APPLICATION **DATE:** _____

LAST NAME: _____ **FIRST NAME:** _____

DATE OF BIRTH: _____ **SSN:** _____ □ **IF N/A**

The RVPCS Sliding Fee Discount Program is for all **RVPCS patients**. Eligibility is determined by the number of persons living in the family/household and total annual income of individuals in the family/household. An updated application must be completed every 12 months to remain eligible.

The application with all required documentation must be completed and approved before this discount can be applied. **Any charges incurred prior to approval date will be the responsibility of the patient and are payable on the date of service. The applicant is aware that false or misleading statements will disqualify him/her from the program**

Section 1: This application requires the patient report their household size and income. To complete your application, please provide the following documentation:

Proof of Income to calculate gross annual income. Accepted forms of income verification includes:

□ Paystubs □ Social Security □ Disability
□ Unemployment □ Federal/State Income Tax Form □ Bank Statement
□ Wages and Tax statement (W-2)
□ No income: *Complete the following if applicable in section 2:* □*Support Verification* □ *Attestation of No Income*

Total Number of People in Household: _____
Total household includes any immediate family members living in the home (i.e. mother/father/children) and any person that lives in the home and mutually contributes to household expenses.

Total Annual Income: $_____
Total income includes employment wages, social security benefits, unemployment benefits, disability benefits, alimony/child support, and pension.

_____ _____
Applicant Signature Date

Section 2: Complete the following if you answered ***NO INCOME***

SUPPORT VERIFICATION

I, _____ verify I provide in-kind assistance or cash assistance/payments to_____. To my knowledge he/she has no income from any other source.

SIGNATURE (of supporter)_____ DATE _____

_____ _____
ADDRESS/CITY/STATE (of supporter) TELEPHONE

ATTESTATION FORM OF NO INCOME

I, _____, am currently unemployed. I have no income at this time.

I do not have any income from any source including Social Security, Disability, Unemployment, Child Support, Spousal Support/Alimony, Retirement/Pension/VA, Welfare, or from the Department of Human Services for myself or dependent household members.

I will inform River Valley Primary Care Services of changes in my employment status and provide proof of income to support my application for assistance through the Sliding Fee Discount Program. I understand that misleading or false statements will prevent me from participating in this program.

_____ _____
Applicant Signature Date

Office Use Only: Reviewed/Entered by: _____ *Approval dates* _____ *to* _____

Qualified for: Slide [A] $20, $0, 50% [B] $25, $5, 40% [C] $35, $8, 35% [D] $45, $10, 30% [E] $50, $12, 25%

River Valley
Primary Care

MEDICAL HISTORY FOR DENTAL CHARTS

Are you under a physician's care now? _____

If so, give reason for treatment: _____

Do you smoke or use tobacco of any other form? _____ If so, what form? _____

List all medications or herbal remedies you are taking at this time: _____

_____

Please circle any problems or illnesses you currently or ever had:

Congenital Heart Defect	Pace Maker	Tuberculosis	Diabetes	Rheumatic Fever
Mitral Valve Prolapse	Epilepsy	Thyroid Problem	Liver Disease	Kidney Problems
History of Heart Attack	Asthma	AIDS/HIV	Arthritis	Joint Replacement
Low Blood Pressure	Stint Placement		Anemia	Abnormal Bleeding
High Blood Pressure	Infectious Hepatitis: (circle one) A B or C			

List any **allergies** or **reactions** you have had to any medications, anesthetics or latex products: _____

_____

Please list any recent changes in your medical history: _____

Is there any information that we should know about your health or previous dental visits? _____

_____

Women: Are you pregnant? _____ How many months? _____ Are you breastfeeding?_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the clinic staff to perform any necessary services with my informed consent that I may need during diagnosis and treatment.

Patient/Guardian Signature: _____ Date: _____

Printed Patient Name: _____Patient Date of Birth:_____

_____

As a Federally Qualified Health Center, River Valley Primary Care Services is required to collect demographic information regarding the patients we serve. The information you provide is confidential.

Section 1: Patient Information

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Social Security Number: _____ **Sex:** ☐ Male ☐ Female **Date of Birth:** _____

Mailing Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Primary Phone:** ☐ Home ☐ Cell ☐ Work _____

Preferred Communication: ☐ No Preference ☐ Phone ☐Mail ☐MyChart (If MyChart, please provide an email)

Email Address: _____ **Marital Status:** ☐ Single ☐ Married ☐ Other: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed: ☐ Yes ☐ No

Ethnic Origin (Please check one): ☐ Latino/Hispanic ☐ Non-Latino/Hispanic ☐ Not Reported/Refused

Race: (Please check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ Not Reported/ Refused ☐ Other: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female (Male-to-Female) ☐ Not Reported/Refused ☐ Transgender Male (Female-to-Male) ☐ Non-Binary (Identifying as any other gender than female or male)☐ Uncertain ☐ Other _____

Sexual Orientation: ☐ Heterosexual/Straight ☐ Homosexual/Gay/Lesbian ☐ Bisexual ☐ Uncertain ☐ Other ☐ Not Reported/Refused

Employer: _____ **Address:** _____ **Phone:** _____

Employment Status: ☐ Full Time ☐ Part-Time ☐ Self ☐ Retired ☐ Not Employed

Homeless Status: ☐ Not Homeless ☐ Homeless shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other _____

Worker Status: ☐ Migrant ☐ Not Migrant ☐ Seasonal **Veteran:** ☐ Yes ☐ No

Special Needs? ☐ None ☐ Glasses ☐ Hearing Aids ☐ Other _____ ☐ Patient Refused Disabled? ☐ Y ☐ N

1. **Pharmacy Name:** _____ **City:** _____ **Mail Order:** ☐ Y ☐ N
2. **Pharmacy Name:** _____ **City:** _____ **Mail Order:** ☐ Y ☐ N

*RVPCS is a federally funded organization and therefore is required to ask our patients their sexual orientation as well as their gender identity in order to identify and reduce health disparities as well as promote culturally competent care. If you do not wish to disclose this information, please mark "Not Reported/Refused"

Section 2: Guarantor (Finically Responsible Party) Information

Guarantor is: ☐ Patient (no need to complete the rest of this section) ☐ Person ☐ Company

Patient's relationship to Guarantor: ☐ Child ☐ Parent ☐ Spouse ☐ Employer ☐ Other: _____

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Social Security Number: _____ **Sex:** ☐ Male ☐ Female **Date of Birth:** _____

Mailing Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Primary Phone:** ☐ Home ☐ Cell ☐ Work

Section 3: Household and Income Information

RVPCS is a federally funded organization and therefore is required to ask our patients about their family income for reporting.
If you are in need of financial assistance, please ask for our Sliding Fee Application.
Please indicate your family annual income (required information for federal reporting)

How many persons are in the household? _____

____$0-$5,000 ____$5,000-$10,000 ____$10,000-$20,000 ____$20,000-$30,000 ____$30,000-$40,000

____$40,000-$50,000 ____$50,000-$60,000 ____$60,000-$70,000 ____$70,000-$80,000 ____$80,000-$90,000

____$90,000+ ____ Do not wish to Disclose/Unknown

Section 4: Insurance Information

Please provide your Insurance card(s), insurance name, policy number, and subscriber's info if different from patient.

Primary Insurance Name and Policy Number: _____

Secondary Insurance Name and Policy Number: _____

Subscriber Information (*If Different from patient or guarantor*):

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Social Security Number: _____ **Sex:** ☐ Male ☐ Female **Date of Birth:** _____

Section 5: Emergency Contact & HIPAA Information

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

I give River Valley Primary Care Services permission to discuss protected health information and to release test results to the following person(s) named above as Authorized HIPAA.

Section 6: Consent to Treatment and Payment Authorization

You are responsible for your own bill.*

As a courtesy, RVPCS will submit charges to your insurance carrier.

Understand that you are financially responsible for all charges incurred whether or not you have insurance.

CONSENT FOR TREATMENT AT RIVER VALLEY PRIMARY CARE:

1. I am aware that the practice of medicine is not an exact science and that the health center offers no guarantees concerning any treatments or examinations I may have here.
2. I authorize the Health Center and its employees to use the information contained in my record for proper medical purposes, and for clinical improvement audits with information that would be de-identified.
3. I authorize the medical staff of the Health Center to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
4. I understand that the services offered at River Valley Primary Care include medical care, mental health, behavioral health, nutrition, and dental care.
5. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

PAYMENT OF BENEFITS AND INFORMATION RELEASE: I request that payment of authorized insurance benefits be made on my behalf to the Health Center for any services furnished to me by the Health Center. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by the Health Center.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received or been offered a copy of River Valley Primary Care's Notice of Privacy Practices.

SIGNATURE: By signing below, I acknowledge that I have read all the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

As the parent/guardian for the identified patient, I am consenting for _____ _____, to receive treatment at any RVPCS location.
Name of child / minor Date of Birth

_____ _____
Patient/Guardian Signature Date

* ☐ *Please check if patient is incarcerated. Must sign above for consent to treat.*