ESCAMBIA COMMUNITY CLINIC
A FEDERALLY QUALIFIED HEALTH CENTER
Proudly providing healthcare since 1992

Escambia Community Clinic * Santa Rosa Community Clinic * Cantonment Medical Center
Urgent Care * Lanza Pediatrics * ECC Lakeview Campus * First Steps Pediatrics * ECC Dental Clinic
ECC at Waterfront Rescue Mission

Dedicated to Meeting the Health Care Needs of Our Community Since 1992

Affordable Health Care on a Sliding Fee Schedule

The following items are **REQUIRED** to process your application for the Sliding Fee Schedule Program. Your application will **NOT** be processed without the requested information. Any information given to Escambia Community Clinics, Inc. or any of its locations will be kept confidential. If the information proves to be **FRAUDULENT** we reserve the right to cancel your Sliding Fee Scale status and bill you in full for all previous visits. Information needed (CHECKLIST):

1. _____ Complete Financial Assistance Form (front and back)
2. _____ Copy of photo ID
3. _____ Copy of at least (1) one paycheck stub from all employed members of household
4. _____ Copy of current year income tax return (if filed) – not "W2"
5. _____ Copy of Food Stamp EBT Card or copy of eligibility letter
6. _____ Medicaid denial letter or proof patient applied for Medicaid for current year
7. _____ Proof of SSI or disability income-presumptive eligibility will be determined, no further information is required
8. _____ Anyone in the household over the age of 18 that is unemployed must provide a written "letter of support" or homeless ID card. The letter of support should include how long they have been living at that location. The supporter needs to sign and date the letter. If available, copy of utility bill to demonstrate address of the supporter for demographic purposes.

BEFORE SIGNING, PLEASE READ THE FOLLOWING:

Escambia Community Clinics, Inc. or its satellite locations must be notified immediately in writing if:

a. There is a change of income (increase or decrease) of any family member in the household listed on original application.
b. Any member of the household, if listed on original application, obtains insurance of any kind.
c. There is a change of mailing address or phone number.

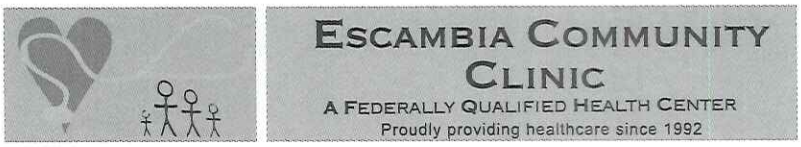
You must pay your fee at the time of each visit. If you do not pay your fee or are not qualified during the current visit, you MUST pay the balance of your account and/or bring in the required documents within 7 business days. If payment or documentation is not received, Escambia Community Clinics, Inc. or its satellite locations reserves the right to **TERMINATE** your eligibility in the Sliding Fee Schedule Program and pursue further collection efforts.

I, _____ have read the above requirements and agree to follow them. I also understand that if I do not comply with the requirements set forth or if **I test positive for any illicit drugs (cocaine, marijuana, heroin, PCP, amphetamine, etc.) and/or medications not prescribed to me, my participation in the program will be terminated immediately. If terminated for a positive drug test, I will be ineligible for the Sliding Fee Scale Program for a period of one (1) year from date of testing and must pass a drug screen before being placed back on the program should I still qualify.** *I also understand that I am responsible for any past due balance(s) owed to Escambia Community Clinics, Inc. or its satellite locations prior to Sliding Fee Schedule eligibility.*

_____ _____
Applicant's Signature Date

_____ _____
Financial Counselor's Signature Date

Form #1200-F12 Feb2015



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PATIENT REGISTRATION FORM

Patient Name:_____

Address:_____
Street City State Zip

Phone: (Home)_____(Cell)_____(Work)_____

Sex: M F DOB:_____ SS#:_____ Marital Status: Single/Married/Separated/Divorced

Spouse:_____ DOB:_____

☐ African American ☐ White/Caucasian ☐ Asian ☐ More than one race

☐ Native Hawaiian/Other Pacific ☐ American Indian/Alaska Native

Are you Hispanic? Yes No (Please circle one)

Emergency Contact: _____ _____
Name Phone #

Does the patient have any type of medical insurance? (Please circle one) Yes No If yes, please circle

Medicaid Share of Cost Family Planning Medicare Disability Other

I declare the information contained on this form to be true and correct to the best of my knowledge and consent to the verification of this information by Escambia Community Clinics, Inc. or its satellite locations. I also authorize Escambia Community Clinics, Inc. or its satellite locations to release any information to any insurance company, the Florida Division of Family Services, Center for Medicare and Medicaid Services or any of their respective agencies that I may have designated as providing insurance in order to secure payment for any treatment provided by Escambia Community Clinics, Inc. or its satellite locations.

_____ _____
Signature Date

Office Use Only

Monthly Income: _____ # in household: _____

Approved financial classification: _____ Financial Counselor initials: _____

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Certification of Low Income Status
Income Assessment Worksheet

Please list income for all dependent family members. This does not include guests, roommates or non-dependent family members.

Source	Amount	Weekly	Bi-Weekly	Monthly	Annually
Salaries and Wages (Self)	_____	☐	☐	☐	☐
Salaries and Wages (Spouse)	_____	☐	☐	☐	☐
Worker's Compensation	_____	☐	☐	☐	☐
Social Security (Self/Spouse)	_____	☐	☐	☐	☐
Social Security (Children)	_____	☐	☐	☐	☐
Child Support/Alimony	_____	☐	☐	☐	☐
Unemployment	_____	☐	☐	☐	☐
Military/Veterans Benefits	_____	☐	☐	☐	☐
Public Assistance	_____	☐	☐	☐	☐
Food Stamps	_____	☐	☐	☐	☐
Pension/Retirement	_____	☐	☐	☐	☐
Other	_____	☐	☐	☐	☐

Please list all dependent family members by NAME, DATE OF BIRTH AND SOCIAL SECURITY NUMBER. Please include yourself.

Name	Date of Birth	Social Security Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Escambia Community Clinics, Inc. reserves the right to inspect your tax return and/or wage statements for previous periods upon request. Eligibility will be updated on an annual basis. If there are any changes in your income status prior to your annual update, you should notify ECC immediately.

I hereby certify that the income and family composition information supplied in the above table is true and correct to the best of my knowledge. I understand this document will be maintained for a period of one year and that falsification of information may result in termination of my eligibility in the medical assistance program (sliding fee schedule).

Signature_____ Date_____