LUNERA HEALTH

Lunera Health Sliding Fee Discount Program Application

In order to apply for discounted services at Lunera Health, we need to know about your family and income. This information is only used to calculate your discount and is **kept confidential**.

Application Information	
Patient Name:	Date of Birth:
If patient isa under 18, Parent/Legal Guardian Name:	Relationship:
Do you have medical insurance? ☐ No ☐ Yes Name of Health Insurance:	
Are you prepared to pay for a full provider visit today? ☐ No ☐ Yes	
Are you currently employed? ☐ No ☐ Yes	

Household Information

Please list ALL MEMBERS of your household. Include those who contribute to the household income and all people for whom you are financially responsible for or those you claim with your taxes. (Additional space for household members is located on the reverse.)
If you have children under the age of 18, GPW Health Center encourages you to apply for Medicaid as the best option for you and your family if you are unable to pay for medical services.
How many people are in your family? # of Children: _____ # of Adults: _____ = Total _____

Name	Date of Birth	Relationship to Patient

Income Verification

Please give an estimate of your household income, include all members of your family. (Income is calculated before taxes.)
My household earns $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly
Please check which items(s) you will provide as proof of income:
☐ Most recent paystub ☐ Letter from Employer ☐ W-2, 1099 form(s), 1040
☐ Award letter or benefit statement ☐ Other/ None

Zero income / No proof of income

If you cannot provide PROOF OF INCOME, have no INCOME, or are experiencing HARDSHIP, please provide a brief description of your current situation:
☐ I cannot provide income ☐ I have no income ☐ I am having difficulties

Certification

By signing this I certify that all of this information is true.

_____ _____/_____/_____

Signature (Patient or legal guardian/closest relative/authorized representative, if patient cannot sign)

Date (Eligibility expires 12 months from date)

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Household Information, Continued		
Name	**Date of Birth**	**Relationship to Patient**

For Office Use Only

Household Size: _____ Household Income: $_____

☐ Approved – 1 year from application date; Slide Approved: ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Denied / Full Fee

Routed to GPW Leadership or Designee for no income/ hardship review:
☐ Slide Approved: ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Approved - Hardship; Timeframe: _____

☐ Denied / Full Fee

Staff Signature: _____ **Date**: ___/____/_____

Reviewer's Notes: _____

Application Validated by Designee: _____

Date: _____