CareMed Discount Program

Information Sheet

Name:____ DOB:________________________

The CareMed Discount Program is a program that allows MedNorth to discount normal charges for services based on household size and total household income.

NOTICE TO PATIENTS:
MedNorth Health Center serves all patients regardless of their ability to pay.
Discounts for essential services are offered based on family size and income.
For more information, please inquire at the front desk or visit our website.

To be considered for sliding fee eligibility:

- You must provide acceptable proof of income.
- List all the people that live in the household.
  - Family is defined as anyone receiving 50% of their support from the head of household.

Providing false information will result in disqualification from the CareMed Program as it violates Federal Law.

You must complete all the attached information and return it along with acceptable proof of income, within 30 days to be considered for the sliding fee scale eligibility.

If the application and required documents are not returned by the date below, you will be responsible for 100% of all charges until all information is received.

Once approved, the CareMed Discount will last for 12 months.

Information must be updated every 12 months **OR** if there are any changes to the household income or size.

Acceptable forms of household income

Current Federal Tax Return	Copy of most recent tax return with form 1040 Tax return Schedule C for self-employed
One month of paycheck stubs	Last 30 days
Company letter stating annual earnings	Letter must contain point of contact and phone number
Official letter/documents	Social security, VA, Courts, Employment Security Commission, Dept of Social Service • TANIF, WIC, food stamps, etc. Disability, Retirement, Student loans/grants
Letter of support	FIT/LINC, SOAR, Transitional home, First Fruit Ministries, Pastors, etc.

Date all information is due at MedNorth: _________________
Are you interested in applying for Medicaid Services? ___________________
You may return this information:

- In person or by mail at: 925 N. 4th St. Wilmington, NC 28401
  OR 240 Calhoun Dr. Wilmington, NC 28412
- Fax: Attention: Patient Access Coordinators, 910-251-1540
- Email: PAC@mednorth.org

If you have any additional questions, please contact us at 910-343-0270.

Date received:________________
Received by: ________________
Account:____________________

CareMed Application

Name *List everyone in the household*	Date of Birth	Relationship	Gross Income *Earnings before taxes/deductions*	Frequency *Weekly, biweekly, Hourly, Monthly, Yearly*
		SELF		

Total Number of family members you are responsible for:____________

***Please provide official IDs along with any insurance cards including Medicaid for those listed above

Do you have a copy of last year's tax return?			_____Yes, please bring a copy, no other documentation is needed. _____No, please answer the questions below.
Did anyone in your household receive payment for:			Please provide a copy of any document below as proof of income:
Employment	Yes	No	• Check stubs within the last 30 days. If paid weekly bring the last 4 check stubs, if paid twice per month bring in the last 2 paystubs. If paid monthly, bring in your last pay stub • Copy of most recent (previous year) tax return (Form 1040) **We do not accept 1099's, W-2's or bank statements as acceptable proof of income.**
Self-employment	Yes	No	• Copy of most recent tax return & Schedule C
Unearned Income: *(Circle all that apply)* Social Security, Veterans Benefits, Workman's Compensation, Unemployment Benefits, Disability, etc.	Yes	No	• Recent statement showing monthly benefit amount
If you are currently unemployed, is there someone supporting you financially?	Yes	No	• The person providing support must complete a letter of support and include a copy of their photo ID.

1. I understand that the information I provide on this form is subject to verification by MedNorth Health Center.
2. I understand and agree to adhere to all terms and conditions of the Sliding Fee Discount program.
3. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to disqualification from the Sliding Fee Discount Program.
4. I understand that it is my responsibility to notify MedNorth Health Center of any changes in income or insurance.

Patient/Guardian Signature:_______________________________ Date:________________

Processed By:____________________________ Date:________________________

Denied_____ Approved_____ Discount Level___________ Valid dates:___________________