Sliding Fee Discount Program - Values In Practice (VIP)

BayouClinic provides primary care and other health care services to individuals and families in accordance with their ability to pay. BayouClinic maintains a Sliding Fee Discount Program (Values in Practice) to determine eligibility for patient discounts based on the patient’s ability to pay.

All patients can apply for the Sliding Fee Discount Program (Values in Practice). The sliding fee scale is based on income and family size for all patients and no other factors.

- **Family** is defined as anyone receiving more than 50% of their support from a head of household, whether living within the same household or not. Students must produce income proof from family members providing more than 50% of their support, and grants for attending school.
- **Income** is defined as gross household income.

**How to Apply**

Complete a BayouClinic-VIP application, mail or deliver to the front desk receptionist. Please include proof of household income for all household members. We accept copies of recent pay stubs, award letters from Social Security, W-2 forms, tax returns, court documents, etc.

We cannot process the application without income verification.

The staff at the BayouClinic is committed to improving access to health care for all. We look forward to working with you to improve the healthcare of our community!

Should you have any questions, please call 251.824.4985
Application for VIP-Reduced Fee Program

PATIENT INFORMATION:

Date: __________________________

Patient Name: __________________________________________________________

Address:  _______________________________________________________________

City, State, Zip:  _________________________________________________________

Telephone:  _____________________________________________________________

Date of Birth:  ________________

Social Security Number: _________________________________

Place of Employment: _________________________________

Health Insurance:  _________________________________

GUARANTOR INFORMATION:  (person responsible for payment)

Patient Name:  __________________________________________________________

Address:  _______________________________________________________________

City, State, Zip:  _________________________________________________________

Telephone:  _____________________________________________________________
FINANCIAL INFORMATION:

**Members of Household** (list ALL members of the household, age, relationship to applicant, and ALL sources of income).

<table>
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<tr>
<th>Name of Household Member</th>
<th>Age</th>
<th>Sources of Income</th>
<th>Monthly Amount</th>
<th>Other info</th>
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Please note that in order to process your application, we need documentation and proof of all sources of income for everyone in your household. If this information is not provided, it may cause a delay in the processing or approval of your application.
AGREEMENT

I, the undersigned, attest to the accuracy and truth of the information provided within this application for reduced fees for services provided at the BayouClinic. The clinic staff may verify the information provided. I agree to report any changes in household income to the BayouClinic within 30 days of the change.

This agreement expires one (1) year from this date.

Printed Name:  

Signature:  

BayouClinic Staff Witness:  

Date:  

For BayouClinic, Inc Use Only
Do Not Write Below This Line

Family Size:  

Income:  

After examination of this applicant’s family size, situation, and financial information, it is my decision that this application is:

Approved  

Denied  

Level A  

Level B  

Level C  

Level D  

Level E

Expiration Date (One year from initial approval):

Denied for reason of  

This status shall remain in effect for 1 year from this date unless otherwise noted, at which time the applicant’s financial situation will be reviewed to evaluate eligibility and classification.

Comments:

_______________________________  ____________________________
Signature, Registration Specialist  Date