| A, B, C, or D |
|---|
| Exp. |

☐RCMS – Gualala ☐RCMS – Point Arena ☐Point Arena Dental Clinic

# Redwood Coast Medical Services - Patient Financial Screening

Patients are required to pay their sliding-scale fees at the time of service. No Patient will be denied services.

Patient Name: ____________________________________________ Date of Birth: _______________

Social Security #: ________________________________

Responsible Person: ____________________________________________ Date of Birth: _______________

Mailing Address: ________________________________________________________________________

Physical Address: ________________________________________________________________________

Home Phone: ________________________ Work Phone: ___________________ Cell Phone: ______________________

**Please list all members of your household – spouse and children under 18 – for whom you have financial responsibility.**

| | Name | Date of Birth | Relationship |
|---|---|---|---|
| 1. | _______________________ | _______________ | _______________ |
| 2. | _______________________ | _______________ | _______________ |
| 3. | _______________________ | _______________ | _______________ |
| 4. | _______________________ | _______________ | _______________ |
| 5. | _______________________ | _______________ | _______________ |

I/We do declare my/our monthly gross household income is: $ ____________________ # in Household____________

You are requested to provide proof of income within your initial 30-day eligibility period. Initial here:________________

*By signing below, I agree that I am financially responsible for treatment I receive. I also declare under penalty of perjury that the answers and documents I have provided are correct and true to the best of my knowledge and belief. I also understand that payment is required at the time of service and, if payments are not made in a timely manner, then the unpaid balance will be turned over to a collection agency.*

*Sliding scale patients needing diagnostic services: I authorize RCMS to release this information to another health care provider in order to qualify for their charity care program for diagnostic tests ordered by RCMS providers.*

| ____________________________ | ____________ | ____________________________ | ____________ |
|---|---|---|---|
| *Patient or Guardian's Signature* | *Date* | *RCMS Staff Signature* | *Date* |

**RCMS Staff Only**

Sliding Scale Account # __________________________

______________________ *Date of discount authorization*

______________________ *Expiration date of authorization*

☐ **Patient or Family Member has emergency Medi-Cal Or High Share of Cost.**

# Patient Copy - Documentation of Income

To be eligible for RCMS's Sliding Scale program, you must provide one of the following proofs of income within 30 days of application or the Sliding scale will expire. You may reapply again.

- W-2 form
- Last year's income tax return
- Most recent pay check stub
- Unemployment check stub
- Notification of Benefit for disability income
- Social Security payment letter or bank statement showing proof of direct deposit of Social Security income
- If self-employed, either prior year's Schedule C income statement or quarterly profit and loss statement
- Worker's Compensation stub or proof of direct deposit
- Signed personal letter stating declaration of income such as income from boarders, odd jobs, or assistance from charity, family for friends

If you are unable to provide RCMS with one of the approved forms of income documentation, or if you have any questions, I am here to support you access to health care. Please call me at:

Yvonne Fuentes
PO Box 629 / 175 Main St.
Point Arena, CA 95468
(707)882-2189 x100
yfuentes@rcms-healthcare.com

If you are eligible for Sliding Scale assistance and provide proof of income or a signed attestation form your eligibility will be evaluated yearly.