NORTHPOINT
Health & Wellness Center

NORTHPOINT DISCOUNT PROGRAM APPLICATION

NorthPoint offers discounted rates for our services, based on your income and family size. We will only use this information to meet your medical, dental, and/or behavioral health needs. We will never use this information to deny services to you.

To apply, fill out this form, print it, and bring it with you to your next visit.

1 HOUSEHOLD AND INSURANCE

Application date: _____ Exp. Date: _____

Patient name: _____ Date of birth: _____

Address: _____ City State ZIP: _____

Are you covered under Medicaid, Medicare and/or other insurance? Yes

If you have private insurance, what is your yearly deductible per person? $ _____

If you have private insurance, is NorthPoint an "In-Network" provider? Yes

Have you or your dependents ever applied for Medicaid/Medicare? Yes

Would you like to apply or re-apply for Medicaid today? Yes

In the spaces to the right, list everyone in your home—including your spouse/partner, all dependents living with you, and anyone else dependent on your income:

First name	Last name	Date of birth	Applying for discount?

2 INCOME

In the spaces to the right, enter your **gross income** (the $ amount received before taxes are taken out). Household income includes ***everyone*** in the home.

Please provide one of the following:
Most recent tax return / recent check stub / bank statement / letter from employer / proof of unemployment

How you're paid?	Amount?	How often?
Work wages	$ _____	
Cash wages	$ _____	
Disability	$ _____	
Social Security	$ _____	
Unemployment	$ _____	
Worker's comp	$ _____	
Child support	$ _____	
Other income	$ _____	

Office use only

Wages are calculated in PM system.

Signature:_____

Date: _____

Patient advised of discount rate.

Initials: _____

Audit stamp:

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3 ACKNOWLEDGEMENT

I promise that the information I entered in this form is accurate and complete to the best of my knowledge. I also promise I will contact/ notify NorthPoint if my insurance or income changes. I understand that I will be financially responsible for **all or some of my care**. I understand that I will be asked to **pay at the time of service**. I give NorthPoint the permission to release any information necessary to establish my family's eligibility for discounted services. I give NorthPoint permission to release my information to Pharmaceutical Companies for auditing purposes, only if I am enrolled in any Bulk Medication Patient Assistance Programs.

Signature: _____ Date: _____

IF YOU DO NOT WISH TO APPLY

☐ I have been given the opportunity to apply for NorthPoint income-based discounts, and I DO NOT WISH TO APPLY FOR THE NORTHPOINT DISCOUNT SERVICES SLIDING FEE PROGRAM AT THIS TIME.

Signature: _____ Date: _____

IF YOU DO NOT AGREE TO THE REQUIREMENTS

Because you do not agree with the requirements to apply for our income-based discounts, you are choosing to be a self-pay patient. This means that you will pay a nominal fee up front at the time of service. You will be responsible for any and all balances due after the provider enters charges for your visit. You will also be responsible for any lab and/or x-ray charges for today's visit. You will not be eligible for any discounts for office charges or lab charges. You will also not be allowed to receive a discount for these charges if a future sliding scale application is completed.

Signature: _____ Date: _____

IF YOU HAVE NO WAY TO PROVE YOUR INCOME

Please complete the information below:

My cash income is: $ _____ I am paid:

Patient: I promise that I have no other way to document my income and that all of the above information is accurate. I understand that this information will be used to determine if I am eligible for a NorthPoint income-based discount.

Signature: _____ Date: _____

Employee: I promise that I asked the applicant/recipient about all the sources of income received by the household. I promise that I used best efforts to obtain other possible sources of documentation before using this form. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Signature: _____ Date: _____