Discount Program Application

We are here for you! Our discount program is available to all eligible patients. We ask that you complete this application as accurately as possible. Eligibility for the discount program is determined using two criteria:

(1) FAMILY SIZE

Financially dependent persons currently living with you including the following: spouse/partner, children from birth/marriage/adoption, and other persons living in your home related to you by birth/marriage/adoption who are considered your dependent(s). An individual is considered a family size of one.

Name_____ DOB _____ Relationship _____ MCC Patient? **YES NO**

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Name_____ DOB _____ Relationship _____ MCC Patient? **YES NO**

Name_____ DOB _____ Relationship _____ MCC Patient? **YES NO**

Name_____ DOB _____ Relationship _____ MCC Patient? **YES NO**

Name_____ DOB _____ Relationship _____ MCC Patient? **YES NO**

(2) INCOME (Please Provide Proof of Income)

All earnings for your family. Earnings include wages, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, alimony, and cash assistance from outside the household. Income does not include non-cash assistance.

Primary Applicant Income: $_____ ☐ Weekly ☐ Monthly ☐ Yearly

Income for other Adults (over 18) in family: $_____ ☐ Weekly ☐ Monthly ☐ Yearly

Total Family Income: $_____ ☐ Weekly ☐ Monthly ☐ Yearly

I understand that if the information I provide is found to be inaccurate, Minnesota Community Care reserves the right to bill me for the entire cost of care at 100% of charges.

$_____ _____ _____

My/Our Total Monthly Income **Signature of Patient/Legal Representative/Parent/Legal Guardian/ Authorized Representative** **Today's Date**

Minnesota Community Care employee completes area below the line

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Completed by:	Eff Date: Term Date:	Total Family Monthly Income: Household Size:	☐ Medical/ Dental/ Pharmacy ☐ Homeless ☐ HealthStart	☐ Cat A ☐ Cat B ☐ Cat C ☐ Cat D ☐ OVER INCOME	☐ POI or Attestation Letter provided ☐ POI or Attestation Letter Due Date:

Place Label Here

Thank you for choosing Minnesota Community Care for your health needs. We are able to provide discounted services as a non-profit community health center using very limited grant funding. The average cost of a visit is $270. We ask you for a payment that is significantly below our actual cost. Your payment allows us to continue operating and serve others in the community.

Eligibility for Minnesota Community Care's discount program is based on income and family size, using the Federal Poverty Guidelines (FPG).

Based on your provided income and family/household size, the patient(s) on this application are assigned to sliding fee category _____ under the _____ program. A nominal fee is due on the date of service for each appointment, which is applied to the patient's overall responsibility as indicated below.

	Medical	**Dental**	**HealthStart**	**Homeless**
Services Covered	Medical and Behavioral Health	Dental ***(selected services only)***	Medical and Behavioral Health provided in school-based clinics	Medical, Dental and Behavioral Health
Applies to	Each eligible family member listed on the application	Each eligible family member listed on the application	Only the patient	Only the patient
Initial Fee due on DOS	**Cat A**: $40 **Cat B**: $50 **Cat C**: $60 **Cat D**: $70	**Cat A**: $50 **Cat B**: $60 **Cat C**: $70 **Cat D**: $80	$0 all categories	$0 all categories
Patient overall responsibility (patients without insurance)	**Cat A**: $40 **Cat B**: 25% of total charges **Cat C**: 50% of total charges **Cat D**: 75% of total charges	**Cat A**: $50 **Cat B**: 25% of total charges **Cat C**: 50% of total charges **Cat D**: 75% of total charges	**Cat A**: $40 **Cat B**: 25% of total charges **Cat C**: 50% of total charges **Cat D**: 75% of total charges	$0
Patient overall responsibility (patients with insurance who are eligible for the SFS)	**Cat A**: $40 or insurance co-pay (lesser of the two) + 0% of deductible amount + 100% of coinsurance amounts **Cat B**: $50 or insurance co-pay (lesser of the two) + 25% of deductible + 100% of coinsurance **Cat C**: $60 or insurance co-pay (lesser of the two) + 50% of deductible + 100% of coinsurance **Cat D**: $70 or insurance co-pay (lesser of the two) + 75% of deductible + 100% of coinsurance	**Cat A**: $50 or insurance co-pay (lesser of the two) + 0% of deductible amount + 100% of coinsurance amounts **Cat B**: $60 or insurance co-pay (lesser of the two) + 25% of deductible + 100% of coinsurance **Cat C**: $70 or insurance co-pay (lesser of the two) + 50% of deductible + 100% of coinsurance **Cat D**: $80 or insurance co-pay (lesser of the two) + 75% of deductible + 100% of coinsurance	**Cat A**: $40 or insurance co-pay (lesser of the two) + 0% of deductible amount + 100% of coinsurance amounts **Cat B**: $50 or insurance co-pay (lesser of the two) + 25% of deductible + 100% of coinsurance **Cat C**: $60 or insurance co-pay (lesser of the two) + 50% of deductible + 100% of coinsurance **Cat D**: $70 or insurance co-pay (lesser of the two) + 75% of deductible + 100% of coinsurance	

Patients above 200% of the FPG are not eligible for the sliding fee discount program..
**Certain services are not covered by any MCC discount program including, but not limited to, INS physicals and circumcisions.*

This application is valid for 6 months after the date approved. If the patient's financial situation changes significantly (e.g. loss of employment, obtain employment, change in household size, etc.) after this application is approved but before 6 months has passed, the patient must inform Minnesota Community Care and has the option to reapply for the Sliding Fee Discount Program.

Patients who do not have third-party insurance and are not eligible for a discount program (or refuse to apply for a discount program) will be required to pay $250 before they receive medical or dental services.

For questions regarding your bill or if you are interested in a payment plan, contact our billing department at **651-602-7500**