PREMIER COMMUNITY HEALTHCARE GROUP, INC.
Discount Fee Application & Agreement

Premier Community Healthcare Group Inc provides essential services regardless of the patient's ability to pay. Discounts are offered depending upon household size and income. Household size is defined as an individual or group of two or more people living in one dwelling who share expenses and living cost. Income is defined as the sum of income, before taxes and deductions, available to the household at the time of application.

I. Household/Family Information

Member's Name(s):	Age	Relationship	Income
_____	_____	**Self** _____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐

II. Income Information
Please provide proof of total household income. One of the following is required: prior year tax return, check stub showing wages/salary for the last 30 days, benefit letter (unemployment, worker's compensation, disability, social security, alimony, pension).

III. Eligibility
With the information you presented today, it has been determined that:

☐ **You qualify** for the Discount Fee Plan checked below. **This plan is in effect for one year from today's date.** If your income or household size changes during this time please notify us immediately.

- ☐ Discount Fee Plan A (Nominal Fee)
- ☐ Discount Fee Plan B
- ☐ Discount Fee Plan C
- ☐ Discount Fee Plan D

☐ **You do not qualify** for our Discount Fee Plan. You will be responsible for paying full fees for your visit. If your income changes or please notify us immediately.

I certify that the above facts are true and correct to the best of my knowledge and that I understand the financial responsibilities associated with the Discount Fee Plan.

_____ _____
Signature of Applicant Date

OFFICE USE ONLY

No. Supported: _____
Gross Income $: _____
Income Period: _____

Care Team Member Signature _____ **Date** _____