Dr.Lawanda Lamar-Bellamy, MD

Crowley Child & Adolescent Clinic Discount Fee Policy

Policy

It is the policy of Crowley Child & Adolescent Clinic to provide essential medical services regardless of the patient's ability to pay. Discounts are offered based upon household income and size. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for six months, after which the patient must reapply.

Discount Application Process

A completed application including required documentation of the home address, household income, and insurance coverage must be on file and approved by the business office before a discount will be granted. If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required.

Adolescent patients seeking confidential care are exempt from the application process, and services are provided at the nominal rate.

Medical	The discount is applied to all in-office services supplied by Crowley Child & Adolescent Clinic.
Pharmacy	Samples are provided, when available, without charge.
Lab & X-ray	The discount is applied to in-office laboratory and x-ray services. Reference laboratory tests and consulting radiology interpretations are excluded.

Services Covered and Excluded

Crowley Child & Adolescent Clinic

Discounted/Sliding Fee Application

It is the policy of Crowley Child & Adolescent Clinic to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This form must be completed for each visit. Please inquire at the front desk if you have questions.

Number of related persons living in your household: ☐

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependent Children under age 18			
Total			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment, and public aid.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print) ☐ Date ☐

Signature ☐

Office Use Only

Patient Name ☐ Discount ☐

Date of Service ☐ Approved by ☐

Crowley Child & Adolescent Clinic
Family Assistance Plan Application

NAME OF HEAD OF HOUSEHOLD		PLACE OF EMPLOYMENT		
STREET	CITY	STATE	ZIP	PHONE
HEALTH INSURANCE PLAN		SOCIAL SECURITY NUMBER		

Please list spouse and dependents under age 18

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				

Source	Self	Spouse	Other	Total
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Rent, interest, dividend, and other income				
Total Income				

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print) _____ Date _____

Signature _____

Office Use Only

Patient Name _____ Discount _____

Date of Service _____ Approved by _____

Verification Checklist (attach copies)	YES	NO
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other	☐	☐
Income: Prior year tax return, three most recent pay stubs, or other	☐	☐
Insurance: Insurance card(s)	☐	☐
Medicaid: Application made or evidence of rejection	☐	☐