CHRIST COMMUNITY HEALTH

Exceptional Fee Reduction Form (Hardship Application)

Patient Name: _____ Patient Date of Birth: _____

Date of Service: _____

Exceptional Fee Reductions (EFR) are for patients of Christ Community Health who have special situations that make it more difficult than usual to pay for healthcare services. To qualify for an EFR, you must be facing a special situation when you receive services at Christ Community and you must have an active Sliding Fee Discount application on file. This application is only good for one day of service, on the day of your appointment.

Please explain the situation that is making it more difficult than usual to pay your visit fee:

___ I or my family member has recently encountered financial hardship, such as loss of a job or housing:

___ I have a verified residence in a shelter or rehabilitation facility.

___ I am an unaccompanied minor seeking state-mandated health care needs.

___ I am seeking only pregnancy, HIV or Hepatitis C testing.

___ My Provider has requested that I schedule more than six (6) medical or three (3) dental visits during 12 consecutive months (must be approved by Provider or relevant Medical Assistant).

___ I am pregnant and not covered by a third-party payor (requires positive pregnancy test).

___ The patient is a newborn who is receiving services during the first 10 months following birth in absence of third-party coverage.

___ Other:

I affirm that all information provided in this application is true and accurate to the best of my knowledge and ability.

Applicant Name: _____Applicant Signature: _____

Date: _____

OFFICE USE ONLY:

*Patient Account Number*_____

Reviewed by: _____ *Date:* _____

Patient is on an Active Sliding Fee Discount of (Circle): A B C D

Patient approved to pay this amount today: ($0. $5, etc) _____

Must be approved and signed by CCH Financial Counselor, Site Manager or Administrator:

Manager's Signature: _____