Rural Health Group Assurance Program Application

RURAL HEALTH GROUP
healthcare that fits your family

Applicant Information

In order to apply for discounted services at Rural Health Group we need to know a little about your family and income. This information is only used to calculate your discount and is **kept confidential.**

First Name:	**Last Name:**	**Date of Birth**: / /

Do you have medical insurance? ☐ No ☐ Yes

Are you prepared to pay for your visit today? ☐ No ☐ Yes

Are you currently employed? ☐ No ☐ Yes

Do you receive any of the following? ☐ No
☐ Unemployment
☐ Public Assistance
☐ Food Stamps
☐ Support from relatives to make ends meet

How many people are in your family? # Children: _____ # Adults: _____ = Total_____

If you have children under the age of 18, Rural Health Group encourages you to apply for Medicaid as the best option for you and your family if you are unable to pay for medical services.

My household earns $ _____ **before taxes every** ☐ Year ☐ Month ☐ Week

By signing this I certify that all of this information is true. I understand that if I lie to get a reduced fee, I am committing fraud. If the number in my household or my household income changes, I agree to report these changes to Rural Health Group as soon as possible.

_____ _____/_____/_____
Applicant Signature **Date** (*Eligibility expires 12 months from date*)

- Please complete the attached 4506-T form ☐ Yes ☐_____
  OR
- Provide a copy of your tax information (1040) or sources of income
  OR
- Most recent pay stub

If you are unable to provide **PROOF OF INCOME**, have **NO INCOME,** or have a **HARDSHIP:**

Brief Description of Financial Situation:

RHG Staff Signature: _____ **Date**:_____/_____/_____

Brief description validated by: _____ Access Coordinator _____/_____/_____

If denied confirmed by: _____ Director of Revenue _____/_____/_____