

Date of Application: _____

Full Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____Social Security #: _____

Marital Status (Circle one): Single Married Divorced Separated Widowed Significant other

Do you or anyone else living with you have health insurance, Medicare or a State Medicaid Card: Yes _____ No _____

If so, please provide a copy of the insurance card, Medicare Card, or State Medicaid Card to the Receptionist.

Have you applied for KY Medicaid: Yes _____ No _____

Household Members	Name	Date of Birth	Relationship to You
Self			
Spouse (or Live in Partner)			
Children or Other			
Children or Other			
Children or Other			
Children or Other			
Children or Other			

Monthly Income	For Yourself	For Spouse	Children or Other Living With You
Gross Wages, Tips, Etc.			
Social Security Income			
Pensions/Annuities			
Child Support Payments			
Self-Employment Income			
Total Income			

Patient Feedback: Do you believe our nominal fee is appropriate payment?

**********PLEASE READ AND SIGN THE BACK OF THIS FORM ALSO**********

Eligible for Sliding Fee: Yes _____ No _____

If Eligible, At What Level: Level A Level B Level C Level D Level E

Financial Policy

We are committed to providing you with the best possible medical care. If you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning your payment for professions services.

1. Our office accepts most insurance plans (Medicare, Medicaid, and commercial insurance). It is your responsibility to:
    a. Bring your insurance card at every visit.
    b. Be prepared to pay your copayment or minimal fee. Payment can be made by cash, check, or credit card.
    c. You will be billed for medical care not covered under your insurance company.

2. If you have insurance in which we do not participate, our office is happy to file the claim upon request; however, you are expected to pay the minimal payment.

3. If you are unable to pay for necessary medical care, you may be eligible for financial assistance and receive a discount based on your household income and family size. It is the patient's responsibility to bring all required documentation before we can process a sliding fee application. Proper proof of income is the most current tax return, the two most recent pay stubs, most recent statement from social services, or a letter from the caregiver with explicit amounts of money that are given on a monthly basis. Sliding scale discounts will be based on the most recent Federal Poverty Index (FPI) guidelines. Patients lacking proper proof of income at the time of their visit must provide this documentation within two weeks. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian of a minor is responsible for the minimal payment at the time of service.

4. If you have questions about your insurance or would like to set up a payment plan, we are happy to help.

Our Clinic staff firmly believes that a good provider/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the Receptionist or Office Manager. Please sign that you have read and agree to this Financial Policy and that all information provided in this form is true and correct to the best of your knowledge.

_____ _____

Signature of Patient or Responsible Party Date

POLICY AND PROCEDURE MANUAL
CLOVER FORK OUTPATIENT MEDICAL PROJECT, INC.

SLIDING FEE SCALE- 2026

MEDICAL SLIDING FEE DISCOUNT SCHEDULE:

SIZE OF HOUSE-HOLD	LEVEL 1 0%	LEVEL 2 25%	LEVEL 3 50%	LEVEL 4 75%	100%
	NOMINAL $10 FEE	PAYS $22	PAYS $32	PAYS $42	PAYS FULL CHARGES
1	$15,960	$15,961 -23,940	$23,941-27,930	$27,931-31,920	$31,921 & higher
2	$21,640	$21,641 -32,460	$32,461-37,870	$37,871-43,280	$43,281 & higher
3	$27,320	$27,321-40,980	$40,981-47,810	$47,811-54,640	$54,641 & higher
4	$33,000	$33,001-49,500	$49,501-57,750	$57,751-66,000	$ 66,001 & higher
5	$38,680	$38,681-58,020	$58,021-67,690	$67,691-77,360	$77,361 & higher
6	$44,360	$44,361-66,540	$66,541-77,630	$77,631-88,720	$88,721 & higher
7	$50,040	$50,041-75,060	$75,061-87,570	$87,571-100,080	$100,081 & higher
8	$55,720	$55,721-83,580	$83,581-97,510	$97,511-111,440	$111,441 & higher
9	$61,400	$61,401-92,100	$92,101-107,450	$107,451-122,800	$122,801 & higher
10	$67,080	$67,081-100,620	$100,621-117,390	$117,391-134,160	$134,161 & higher
11	$72,760	$72,761-109,140	$109,141-127,330	$127,331-145,520	$145,521 & higher
12	$78,440	$78,441-117,660	$117,661-137,270	$137,271-156,880	$156,881 & higher

Notes: The 2026 federal poverty guideline increases by $5,680 for each additional family member.

POLICY AND PROCEDURE MANUAL
CLOVER FORK OUTPATIENT MEDICAL PROJECT, INC.

SLIDING FEE SCALE- 2026

PHARMACY SLIDING FEE DISCOUNT SCHEDULE:

SIZE OF HOUSE-HOLD	LEVEL 1 0%	LEVEL 2 25%	LEVEL 3 50%	LEVEL 4 75%	100%
	NOMINAL $10 FEE	PAYS $22	PAYS $32	PAYS $42	PAYS FULL CHARGES
1	$15,960	$15,961 -23,940	$23,941-27,930	$27,931-31,920	$31,921 & higher
2	$21,640	$21,641 -32,460	$32,461-37,870	$37,871-43,280	$43,281 & higher
3	$27,320	$27,321-40,980	$40,981-47,810	$47,811-54,640	$54,641 & higher
4	$33,000	$33,001-49,500	$49,501-57,750	$57,751-66,000	$ 66,001 & higher
5	$38,680	$38,681-58,020	$58,021-67,690	$67,691-77,360	$77,361 & higher
6	$44,360	$44,361-66,540	$66,541-77,630	$77,631-88,720	$88,721 & higher
7	$50,040	$50,041-75,060	$75,061-87,570	$87,571-100,080	$100,081 & higher
8	$55,720	$55,721-83,580	$83,581-97,510	$97,511-111,440	$111,441 & higher
9	$61,400	$61,401-92,100	$92,101-107,450	$107,451-122,800	$122,801 & higher
10	$67,080	$67,081-100,620	$100,621-117,390	$117,391-134,160	$134,161 & higher
11	$72,760	$72,761-109,140	$109,141-127,330	$127,331-145,520	$145,521 & higher
12	$78,440	$78,441-117,660	$117,661-137,270	$137,271-156,880	$156,881 & higher

Notes: The 2026 federal poverty guideline increases by $5,680 for each additional family member.

POLICY AND PROCEDURE MANUAL
CLOVER FORK OUTPATIENT MEDICAL PROJECT, INC.

SLIDING FEE SCALE- 2026

DENTAL EXAMINATIONS SLIDING FEE DISCOUNT SCHEDULE:

SIZE OF HOUSE-HOLD	LEVEL 1 0%	LEVEL 2 25%	LEVEL 3 50%	LEVEL 4 75%	100%
	NOMINAL $10 FEE	PAYS $22	PAYS $32	PAYS $42	PAYS FULL CHARGES
1	$15,960	$15,961 -23,940	$23,941-27,930	$27,931-31,920	$31,921 & higher
2	$21,640	$21,641 -32,460	$32,461-37,870	$37,871-43,280	$43,281 & higher
3	$27,320	$27,321-40,980	$40,981-47,810	$47,811-54,640	$54,641 & higher
4	$33,000	$33,001-49,500	$49,501-57,750	$57,751-66,000	$ 66,001 & higher
5	$38,680	$38,681-58,020	$58,021-67,690	$67,691-77,360	$77,361 & higher
6	$44,360	$44,361-66,540	$66,541-77,630	$77,631-88,720	$88,721 & higher
7	$50,040	$50,041-75,060	$75,061-87,570	$87,571-100,080	$100,081 & higher
8	$55,720	$55,721-83,580	$83,581-97,510	$97,511-111,440	$111,441 & higher
9	$61,400	$61,401-92,100	$92,101-107,450	$107,451-122,800	$122,801 & higher
10	$67,080	$67,081-100,620	$100,621-117,390	$117,391-134,160	$134,161 & higher
11	$72,760	$72,761-109,140	$109,141-127,330	$127,331-145,520	$145,521 & higher
12	$78,440	$78,441-117,660	$117,661-137,270	$137,271-156,880	$156,881 & higher

Notes: The 2026 federal poverty guideline increases by $5,680 for each additional family member.

DENTAL LAB, SUPPLIES & EQUIPMENT SLIDING FEE DISCOUNT SCHEDULE:

SIZE OF HOUSE-HOLD	LEVEL 1 0%	LEVEL 2 25%	LEVEL 3 50%	LEVEL 4 75%	100%
	NOMINAL $30 FEE	PAYS 25%	PAYS 50%	PAYS 75%	PAYS FULL CHARGES
1	$15,960	$15,961 -23,940	$23,941-27,930	$27,931-31,920	$31,921 & higher
2	$21,640	$21,641 -32,460	$32,461-37,870	$37,871-43,280	$43,281 & higher
3	$27,320	$27,321-40,980	$40,981-47,810	$47,811-54,640	$54,641 & higher
4	$33,000	$33,001-49,500	$49,501-57,750	$57,751-66,000	$ 66,001 & higher
5	$38,680	$38,681-58,020	$58,021-67,690	$67,691-77,360	$77,361 & higher
6	$44,360	$44,361-66,540	$66,541-77,630	$77,631-88,720	$88,721 & higher
7	$50,040	$50,041-75,060	$75,061-87,570	$87,571-100,080	$100,081 & higher
8	$55,720	$55,721-83,580	$83,581-97,510	$97,511-111,440	$111,441 & higher
9	$61,400	$61,401-92,100	$92,101-107,450	$107,451-122,800	$122,801 & higher
10	$67,080	$67,081-100,620	$100,621-117,390	$117,391-134,160	$134,161 & higher
11	$72,760	$72,761-109,140	$109,141-127,330	$127,331-145,520	$145,521 & higher
12	$78,440	$78,441-117,660	$117,661-137,270	$137,271-156,880	$156,881 & higher

Notes: The 2026 federal poverty guideline increases by $5,680 for each additional family member.

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