ElevaCare

Reduced Fee Application

Thank you for choosing ElevaCare for your needs. To ensure your application is processed promptly, please complete this form. Proof of household income is required. You must provide 3 most recent paystubs for any household members 18 years of age or older that work OR an income tax return from the previous year. If you are eligible for a reduced rate we will let you know the amount you will owe each appointment. REDUCED FEES ARE DUE AT THE TIME OF SERVICE.

If you have any questions, please call our Billing Department at 507-935-2099.

Name of Head of Household: _____ ☐ **Employed** ☐ **Unemployed**

Address: _____ **DOB:** _____

Phone: _____

Health Insurance Information:

Name of Health Insurance Company: _____ **Deductible:** _____

Member ID #: _____ **Co-pay:** _____

Have you applied for Medicaid (MA)? ☐ **Yes** ☐ **No** **Out of Pocket Maximum:** _____

Please list all members of the household:

Name	DOB	Are they a client at our Center?

Annual Household Income

Source	Self	Spouse	Other	Total
Annual Income				
Social Security				
Alimony, Child Support				
Unemployment Income				
Total Income				

Verification Checklist (attach copies):

Please provide 3 most recent paystubs for any household members age 18 or older that work OR an income tax return from the previous year.

Brief explanation of why you are applying for a reduced fee:

Sign & Date:

I certify that the information shown above is correct and understand verification is required for approval. Incomplete applications will be denied.

Name (Print) **Signature** **Date**