MATHIESEN MEMORIAL HEALTH CLINIC

P.O.Box 535, 18144 Seco St.
Jamestown, CA 95327

Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /	Social Security # - -	Do you have insurance? (circle one) Yes No		
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size			
Name	**Date of Birth**	**AGE**	**Relationship**
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

Household Income

Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

Phone 209-984-4820
Fax 209-984-4825

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The primary requirement for consideration is that you have been **DENIED** by Medi-Cal. If you currently have Medi-Cal, DO NOT complete the remainder of this form.
Have you applied for Medi-Cal, and been DENIED benefits within the last 60 days?

☐YES ☐NO

Please return this completed form to the receptionist. Along with the following,

A. **Copy of you Medi –Cal Denial**
B. **your three most current paystubs or Bank statement ,**
C. **child support check stubs, social security statements, or disability/workers comp check stubs.**

Failure to provide sufficient proof will result in the return of your application and delay in approval.

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Mathiesen Memorial Health Clinic if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Mathiesen Memorial Health Clinic. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____

Name_____

Signature:_____

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VERIFICATION AND DETERMINATION

Applicant Name:_____

1. ☐ Copy of Medi-Cal denial form attached
2. ☐ Monthly income verification attached
3. ☐ Monthly income computation completed for:

☐ Applicant	$_____
☐ Spouse	$_____
☐ Other	$_____
Total Monthly Income	$_____

Fee Reduction Recommendation

- A. 100%
- B. 75%
- C. 50%
- D. 25%
- E. 0%

Length of Reduction

- A. 90 Days
- B. 60 Days
- C. 30 Days

Verification and determination by_____ Date_____
RECEPTIONIST

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