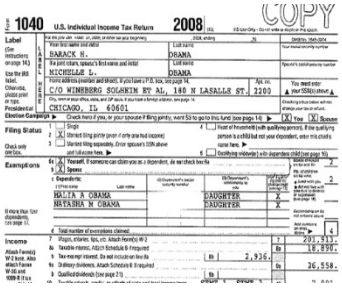
OPTIMUS HEALTH CARE

Picture ID, Passport or a driver's license

Your Social security card (OPTIONAL)/Insurance Card

Proof of address (can be like gas or electricity bill)
Proof of income (4 last pay stubs)

Letter from Employer (cash or self-employed)
Letter from person who is your economical support
Recent income tax return from the year



DOCUMENTS AND REQUIREMENTS

Number of people in your household_____ RETRO: _____

IDENTIFYING DOCUMENTS

1. ____ Complete Application
2. ____Photo ID (Permanent Resident Green Card, Passport, Driver License or Identification from your original Country)
3. ____ Social Security Card (Child)
4. ____ Birth Certificate (Child)
5. ____ State Insurance card, Husky, Medicaid or Private Insurance for all members In your family
6. ____ Proof Of Address (Utility Bills or Hospital Bills)

Household Income: **$**_____

1. ____ Most recent Tax Return (IRS1040, 1040A,104OEZ), W-2/Return Forms
2. ____ Bank Statements (the last 2 months).
3. ___ Pay stubs for last 4 weeks
4. ___ Letter from Employer if cash or self-employed
5. ___ Letter from the person who is your economical support
6. ____ Alimony and Child support letter
7. ____ Food Stamp or Cash Assistance-Letter from Department of Social Service
8. ____ SSI or Pension

Additional Information Request

1.____ Rent or Mortgage Receipt
2.____ Department of Social Services Denial Letter

Sliding Fee Discount Program
Application

It is the policy of Optimus Health Care, Inc. to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to _____ to determine if you or members of your family are eligible for a discount.

The discount will apply to all services you receive at Optimus Health Care, except those services or equipment that are purchased from or provided by other vendors, including medical and dental laboratory testing services laboratory testing equipment and supplies, drugs and X-ray interpretation by a consulting radiologist and such other services. This form must be completed every 12 months or if your financial situation changes.

Name:
Address:
Telephone:

Members of Household

Relationship	Name	Date of Birth	Social Security	Place of Birth
Self				
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				
Dependent				

Employment Income:

Head of Assistance Group:
Name of Employer:
Employer Address:
Average Weekly Gross Income:
Is there another member of assistance group employed? Y___ N___
Name of Employer:
Employer Address:
Average Weekly Gross Income:

Medical Insurance:

Policy Holder: _____Primary: _____Policy # _____
Policy Holder: _____Secondary: _____Policy # _____

Source of Income:

Type	Yes	No	Amount
Social Security			
State Welfare			
Workers' Compensation Insurance			
Veteran's Benefits			
Pension			
Child Support/Alimony			
Other (Type and Source)			

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

Room and board provided by: _____.Relationship: _____

I certify that all information given on this application is true and accurate to the best of my knowledge. I authorize OPTIMUS HEALTH CARE to obtain information from others in order to verify the information contained in this application. I agree to notify OPTIMUS HEALTH CARE of any changes in my income and or any changes in any other information provided on this application.

Print Name of Applicant: _____

Signature of Applicant:_____ Date: _____

Signature of Optimus Representative: _____ Date _____