

Pioneer Medical Clinic

PO Box 340, Pierce Idaho 83546

208-476-8541

APPLICATION FOR HILL BURTON ASSISTANCE

Name: Last		First	M.I.
Address: Street		City/State	Zip
Social Security #	Home/cell phone	Employer	

	Last 12 months	Last 3 months x 4	Family size
Patient's gross income			
Other family income			
Total family income			

Type of service rendered/requested: _____

Date(s) of service: _____

I certify the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my clinic charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the clinic the amount received for clinic charges. If any information I have given proves to be untrue, I understand the clinic may re-evaluate my financial status and take whatever action becomes appropriate.

Applicants signature: _____ Date: _____

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Eligibility Determination (For office use ONLY)

Date application received: _____ Income verified yes no

Type of verification: _____

- The application is approved for care at no charge *Conditionally approved for care at no charge
 Or a reduction of _____% of allowable charges under Category B of the Poverty Income Guidelines.
 Amount provided as uncompensated services is \$ _____.

*Condition(s): _____

- The applicant's request for free or reduced care services has been denied for the following reasons:

Date of conditional determination: _____ Date of final determination: _____

Date applicant notified: _____ Approved by: _____



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