AOMA GRADUATE SCHOOL *of* INTEGRATIVE MEDICINE

Student Clinic Reduced Rate & Herbal Outreach Program

The Student Clinic Reduced Rate and Herbal Outreach Program is designed to help patients with medical needs who, due to financial hardship, are unable to afford acupuncture treatments and herbal prescriptions at the AOMA student intern clinic. Patients with financial hardships include those who only receive Social Security or disability checks, are unemployed, or have extraordinary circumstances.

The patient must complete the first page of this application in sufficient detail to be considered for AOMA's Reduced Rate and Herbal Outreach Program**. Patients are approved for this program on an annual basis and will be re-evaluated by a student intern every six (6) months in January and June.** If you are approved, you will receive an approval letter and your name will appear on a list at each AOMA Clinic & AOMA Herbal Medicine location. It is the patient's responsibility to inform the clinic front desk and/ or AOMA Herbal Medicine staff of their discount status. The approval committee meets monthly. Applications not received by meeting date will be processed at the next month's meeting.

The following documents are required to process your application. Proof of income must include income of **all household members.** All financial information provided will be shredded after reviewed.

REQUIRED DOCUMENTS:

1. Completed, signed and dated application
2. Referral by Student Intern Form
3. PROOF OF INCOME (provide proof for each category that applies to any family member with-in the residence)
    - Earned income – check stubs for the last month or employer's written statement.
    - Self-Employment Income – Last year's IRS tax return complete with Schedule C or business and receipts.
    - Other Income (Social Security, SSI Unemployment Compensation, Educational Grants/Loans, Child Support, Pensions/Union Benefits or Sponsor's Income) – Current award letter, check or copy of current check, or official written statement for agency providing benefit.
4. PHOTO INDENTIFICATION
    - Current driver's license or other picture identification.

After the application is processed by the committee, please allow up to two weeks for notification by mail. Any questions pertaining to this application can be answered by the clinic reception staff (512-467-0370).

General Information

Applicants Name ___________________________________ Date of Birth ______________________
Address _______________________________City _____________ State ______ Zip _____________
Home Phone # __________________________ Work Phone # _________________________________
Email ____
Relationship Status ___________ # of adult household _________ # of dependents _____________

Household Income

Applicants Employer ________________________________Occupation _______________________
Full Time / Part Time _______________ # of hours a week __________________________________
If unemployed, date of unemployment: _______ Are you receiving unemployment Yes / No _________
If *YES* – Beginning date ___________________ Amount receiving weekly _______________________

Spouse / Significant Other's Employer __________________Occupation _______________________
Full Time / Part Time _______________ # of hours a week __________________________________
If unemployed, date of unemployment: _______ Are you receiving unemployment Yes / No _________
If *YES* – Beginning date ___________________ Amount receiving weekly _______________________

Do you receive any of the following? If so, please attach supporting documentation.

Food Stamps Yes No Snap Yes No

Disability/SSI Yes No

Are you insured? Yes No With whom? UHC BCBS Other _____________

Please include insurance information (member ID#, group #) if you would like us to verify acupuncture coverage.

Applicant's Medical Information

Description of health condition and how it affects your daily activity: ___________________________
____
____
____
____

Explanation of financial hardship (include details regarding your current income including any government or family assistance): ____
____
____
____

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge. I understand that incomplete applications are not able to be processed & will be denied.

Patient's Signature____________________________________ Date: ___________________________

Patient Name (print): __________________________ Patient's phone: __________________________

To be completed by student intern (Please print legibly)

Patient's Name ______________________________ Term/Year _____________________________

Patient's current medical condition: ____
____
____

Relevant medical history: ____
____
____
____

Degree to which medical condition affects daily life and ability to work: _________________________
____
____
____

Expected desires/outcomes of recommended treatment plan: ________________________________
____
____
____

Additional relevant information: ____
____
____
____

Recommended treatment plan (# of treatments and frequency of treatments and/or herbal prescription): ____
____
____

Number of treatments ___________ per **week** or **month** (please circle one)

Frequency of Herbal prescription: **weekly**, **monthly,** or as **needed** (please circle one)

Student Intern's Signature ____

Intern name (printed) ________________________________ Date ______________________

Supervisor's Signature ______________________________ Date ______________________

OFFICE USE ONLY

Returning applicant? Yes No If yes, list previous term and discount rate: ____________________

Circle one: Approved Denied Approval Period (year): _________________________________

Approved by: ____ Date ______________________

Additional Comments: ____

RRP Approval:

_____ $15

_____ $ 5

_____ Free

H.O. Approval:

______ Student Discount

______ Half Price

______ Free