Family Health Care

Sliding Fee Discount Application

It is the policy of Family Health Care to provide health care services to patients in need. Discounts are offered to members of households with combined income of less than double the Federal Poverty level. If you prefer not to provide this information, please sign the following waiver and return this form to the front desk. Thank you.

Waiver:

I choose **not** to provide the following information at this time. **I am waiving my right** to any sliding fee discount to which I may otherwise be entitled.

_____	_____	_____
Patient Name (Please print)	**Signature of Patient or Guarantor**	**Date**

Application:

In order to determine the percentage for which you qualify, please complete the following information and return to the front desk.

 # OF PEOPLE SUPPORTED BY THE HOUSEHOLD INCOME BELOW (Please List):

First Name	MI	Last Name	Birth Date	Relationship	Patient? Y/N

Note: Include income from all people in the household and from all sources, including wages, tips, Social Security, disability, pensions, annuities, veteran payments, military, self employment, alimony, child support, unemployment, public aid, and any other income from any other source. Supporting documentation is required before the Sliding Fee Discount can be approved, and approved discounts will be valid for up to one year. **Acceptable forms include: copies of two recent checks/stubs, W-2, recent tax return, public assistance or Social Security check/stub or letter of award, Medical Assistance or Dept. of Social Services Certification Letter, proof of Governmental Assistance, or proof of zero or limited income.**

Total Household Income (Please Complete Only one Column):

Member	Annual	Monthly	Bi-Weekly	Weekly
Self				
Spouse				
Children				
Relatives/others				
Total				

Certification:

I certify that the household size and income information shown above is correct. **I understand that the documentation supporting my household financial position is required before my discount can be approved.** I understand that I must update this information if my situation changes, and that a new Discount Application must be completed at least every twelve (12) months. I have received information explaining the program and I understand and agree to abide by the terms. **I understand that if I am a self –pay patient, I will be asked to pay a nominal fee of $20 (medical), $5 (behavioral health), and $35 (dental) prior to receiving any health care services.** I understand that by signing below I acknowledge that the information I have provided is honest and up to date information**. I understand that Family Health Care has the right to discharge me as a patient if I have falsely provided information in regards to my household and its income**.

_____	_____	_____
Patient Name (Please Print)	**Signature of Patient or Guardian**	**Date**

Office use only

Documentation	%	Date
Received/Reviewed		

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Sliding Fee Discount Patient Information

Patients with household income up to and including 200% of the Federal Poverty Guidelines may apply for the Sliding Fee Scale Discount.

1. Any patient may apply for a Sliding Fee Discount by filling out the Sliding Fee Scale Application.
2. Signage will be posted that a Sliding Fee Discount is available to all qualifying patients.
3. The patient must also present one or all of the following:
    a. Salary and wages – Tax Return (1040) or 2 check stubs from current employer or copy of telefile worksheet with confirmation number.
    b. Letter from employer, or Form 4506-T (if W-2 not filed).
    c. Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business or the previous year's tax return.
    d. Social Security/ Disability/Pension – Statement from agencies
    e. Unemployment- Notice of unemployment compensation eligibility or determination of unemployment compensation benefits
    f. Workers compensation – Statement from agency
    g. Child Support – Statement from Child Support Enforcement Agency
    h. Pension – Statement
    i. Any Other Income – written proof
4. The combination of family income and number of dependents determines the adjustment percentage on the sliding fee scale.
5. The Sliding Fee Scale has at least 4 income brackets starting at 100% and up to and including 200% of Federal Poverty Guidelines. .
6. A Sliding Fee Scale Policy will be given to the patient before filling out the sliding fee scale application. The Sliding Fee Scale Application will be signed by the patient and initialed by the Biller or designated Front Desk Staff and filed in the patient's chart along with the proof of income.
7. Patient will have 30 days from date of service to bring in income verification. If income verification is not received with in those 30 days, a statement will be sent to the patient for the full charge amount. If after 60 days from date of service, income verification is still not brought in, patient will be expected to pay 100%.
8. A new Sliding Fee Scale Application can be requested if there is a change in income. Otherwise, the sliding fee scale needs to be completed annually.
9. For the purpose of income determination, a Family is defined as a group of two or more persons related by birth, marriage, adoption, guardianship or household of individuals.
10. A nominal fee payment will be requested at the time of each office visit for medical, dental, and behavioral health services. If a patient has both a medical and behavioral health visit on the same day, the behavioral health fee can be waived as long as the medical fee is paid.
11. Financial Hardship Applications are available if the patient requests the nominal fee be deferred or if there is refusal to pay (if a patient presents saying they cannot pay due to no available funds). Patients will be seen by the provider, however, are required to complete the Financial Hardship Application at date of service.
12. Patient agrees to pay to Family Health Care all insurance proceeds received by the patient for services provided by Family Health Care.
13. Services not covered under the Sliding Fee Scale: Vaccines, non-routine medical supplies, medical labs, dental labs, and any outside services. The provider will go over extra costs when a treatment plan is established at the time of visit. Patient will then be billed for these additional costs.