Sliding Fee Discount Program Application

Valid from April 19th, 2022 through April 30th, 2023

It is the policy of Family Health Services, LLC, to provide patient-centered primary care regardless of the patient's ability to pay. Discounts are offered based upon total household income and the number of persons living in the household. A sliding fee schedule is used to calculate the basic discount and is updated each year using federal poverty guidelines.

A **fully** completed application including verification of income must be on file and approved by the business office before a discount will be applied.

PERSONAL INFORMATION

Last Name:________________________________ First Name: _____________________________

Date of Birth:_______/_______/__________
MM DD YYYY

Home Address: _____________________________ Mailing Address:_____________________________

______________________________ ______________________________

City/Zip Code: ______________________________ City/Zip Code: _____________________________

Phone Number: (Home) _____________________ Phone Number: (Cell) _________________________

Are you a college student under the age of 23, living at home with your parents? ***Yes*** ***No***

HOUSEHOLD SIZE INFORMATION – Individuals related by birth, marriage, or adoption and residing together.

- **Any member 18 years of age or older residing in the household must provide proof of income**.

1. Name/Relationship	Age	2. Name/Relationship	Age
3. Name/Relationship	Age	4. Name/Relationship	Age
5. Name/Relationship	Age	6. Name/Relationship	Age
7. Name/Relationship	Age	8. Name/Relationship	Age

FINANCIAL INFORMATION

Self	Spouse	EMPLOYER NAME & PHONE #	START DATE	DATE ENDED	HOW OFTEN PAID

INCOME SUMMARY TABLE

Sources	Total Household Income	Accepted Documents
Wages		Last federal income tax return or last two paycheck stubs prior to the signature date on this application.
Interest/Dividend Income		Bank, credit union, savings statement or 1099.
Self-Employment; Rental Income		Statement of income and expenses for the current year.
Public Assistance, Social Security/Supplemental Security, Food Stamps		Award letter(s) listing amount received in the current year. If you receive more than one, please add them together.
Unemployment Compensation		Unemployment compensation benefit award letter for the current year.
Worker's Compensation		Worker's compensation benefit award letter for the current year.
Child Support, Alimony		Divorce decree stating child support or alimony received.
Retirement Income		Letter supplied by system administrator with monthly benefit amount for the current year.
Veteran's Payments		Letter supplied by veteran's administration with monthly benefit amount for the current year.
Assistance from Family or Friends		A notarized statement from family or friends explaining any financial help that they give you.
Other Income (Specify)		
TOTAL		

SELF-DECLARATION OF INCOME – Please provide as much information as possible as to why you cannot provide proof of any income. I.e., worked odd jobs for cash; started new business….

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I understand that all the information given may be confirmed by Family Health Services. I also understand that providing false information is considered fraud and will result in a denial of the Sliding Fee Scale Program application and that I will be responsible for the payment of charges for the services provided.

Applicant Signature (required):_______________________________________Date: ___________

ELIGIBILITY INFORMATION – FOR OFFICE USE ONLY

Annual Gross Income: $ ____________________

☐ Application Approved

☐ Application Denied

Patient Account Number: _____________

Number of Household Members: _______

You will be billed for:

Medical & BH Services

- ☐ Level 1 - $20
- ☐ Level 2 - $40
- ☐ Level 3 - $60
- ☐ Level 4 - $80
- ☐ **No Discount** - $150 due at the time-of-service, Patient will be billed for remainder of balance

Dental Services

- ☐ Level 1 - $20/$80/$800
- ☐ Level 2 - $60/$120/$900
- ☐ Level 3 - $100/$200/$1,000
- ☐ Level 4 - $120/$240/$1,100
- ☐ **No Discount** - $150 due at the time-of-service, Patient will be billed for remainder of balance

Processed By: ____ Date: _______________

PENDING APPLICATION – FOR OFFICE USE ONLY

Application is pending due to incomplete or non-submission of: Completed On: __________

☐ Proof of income: ____

☐ Application incomplete: ____

☐ Other: ____

Processed By: ____ Date: ____________

DECLINE SLIDING FEE SCALE PROGRAM

It is the policy of Family Health Services, LLC, to provide all resources available for payment of Medical, Behavioral Health and Dental services. Patients who may be eligible for coverage through Medicaid or Medicare but **decline** to cooperate with a financial advocate in applying for such programs or fail to comply with established eligibility processes will **not be eligible for financial** assistance for that episode of care.

I am declining enrollment application services offered by Family Health Services, LLC and understand by declining I may not be eligible for financial assistance.

Applicant Signature (required):______________________________ Date_________________

Witness Signature____ Date_________________