Sliding Fee Discount Program Application

Valid from May 19th, 2021 through May 1st, 2022

It is the policy of Family Health Service of Erie County 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.

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	NAME OF EMPLOYER 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…..

_____

_____

_____

I understand that all of the information given may be confirmed by Family Health Services of Erie County. 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 $_____ Patient #_____

☐ Application Approved Number of Dependents _____

☐ Application Denied

You will be billed for:

( ) Level 1 $20.00
( ) Level 2 $40.00
( ) Level 3 $60.00
( ) Level 4 $80.00
( ) No Discount, $150.00 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

It is the policy of Family Health Services (FHS) to provide all resources available for payment of medical 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 and understand by declining I may not be eligible for financial assistance.

Patient Signature_____Date_____

Witness Signature_____Date_____