SLIDING FEE DISCOUNT PROGRAM

The Sliding Fee Discount Program is offered based on household income and number of persons in the household. **Discounted services include medical services, dental services, behavioral health services, substance use disorder group services, physical and occupational services and pharmacy prescription medications provided at the Family Health Center, Inc.**

Family Health Center, Inc. will collect a minimum payment at the time of service. Please be aware that the balance will be billed to you after services are provided. Intrauterine device (IUD), implantable contraceptive, hormone injections and dental lab expenses, i.e. third party fees associated with dental procedures, including but not limited to laboratory fees associated with crowns and dentures are non-eligible for the sliding fee discount program. If you have further questions, please contact the Patient Accounts Department.

You must complete a sliding fee discount program application, and attach proof of income. If the proof of income presented does not belong to the patient, the person or persons in the household must appear with picture identification during the application process. **If you do not have proof of income during the visit, you have 30 days to complete and return this information. Otherwise you will not receive the discount and will be responsible for FULL charges. The 30-day waiver will be honored on the day of the patient's visit for prescriptions written by FHC providers.** Proof of income can be two bi-weekly paycheck stubs, four weekly paycheck stubs, social security benefits statement, unemployment benefit statement or any source of income. If you do not have income, it is possible to use unemployment office documentation, or an acceptable letterhead from a pastor/minister stating that you are unemployed and do not have any income.

Sliding fee discount certification is completed once per year. Patients are required to notify the Family Health Center, Inc. of any changes in income.

I have read and understand the sliding fee discount program information. I understand that:

1. **Family Health Center, Inc. will collect a minimum payment at the time of service.**
2. **The balance will be billed to me after services are provided.**
3. **I must complete the sliding fee discount program application, and attach proof of income with picture identification.**

Patient Name: _____ DOB: _____

Responsible Party Name: _____

Responsible Party Signature: _____ Date: _____

#3-003
03/07/2022

SLIDING FEE DISCOUNT PROGRAM APPLICATION

The Family Health Center, Inc. offers the sliding fee discount program for persons earning between 0% to 200% of the federal poverty level. Please complete the application and provide identification to determine eligibility for the program.

Patient Name: _____
(Last) (First) (Middle Initial)

Responsible Party: _____
(If different from patient) (Last) (First) (Middle Initial)

Responsible Party Date of Birth: _____ SSN # _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____-_____ Work Phone: _____-_____

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

I certify the information in this application is true. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee discount program and will subject me to penalties under Federal Laws. If acceptance to the sliding fee discount program is obtained under this application, I will comply with all rules and regulations of Family Health Center, Inc.

Responsible Party Name: _____

Responsible Party Signature: _____ Date: _____

#3-003
03/07/2022

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Number of Persons in Household: _____

Name	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Responsible Party Name: _____

Responsible Party Signature: _____ Date: _____

SLIDING FEE DISCOUNT PROGRAM APPLICATION

This section to be completed by Family Health Center staff.

Type of Income (Attach proof of income)	Income Calculations
Wages, Salaries, Commission or Fees (check stubs, federal income tax return)	
Social Security or disability payments	
Public Assistance	
Unemployment Benefits	
Government Pension or Veteran Benefits	
Alimony or Child Support	
Other Income	
Total Annual Income	

No income: Unemployment office documentation Acceptable letterhead from a pastor/minister

Other documentation (Specify: _____)

Sliding Fee Discount Category (refer to pages 11-14 for SFD schedule)	**A**	**B**	**C**	**D**
% visit charges to be billed (Medical):	**$15**	**25%**	**35%**	**50%**
% visit charges to be billed (Dental):	**$25**	**25%**	**35%**	**50%**
% visit charges to be billed (BH):	**$25**	**25%**	**35%**	**50%**
% visit charges to be billed (PT/OT):	**$25**	**25%**	**35%**	**50%**
% visit charges to be billed (Group)	**$15**	**25%**	**35%**	**50%**

Certified by: _____ Date: _____

This application is active **From**: _____ **To**: _____

(After initial certification, date for Recertification is <u>One Year with income</u>)

I have read and understand the sliding fee discount program information. I understand that:

1. **Family Health Center, Inc. will collect a minimum payment at the time of service.**
2. **The <u>balance will be billed to me</u> after services are provided.**
3. **I must complete the sliding fee discount program application, and attach proof of income with picture identification.**

Responsible Party Name: _____

Responsible Party Signature: _____ Date: _____