POLICY ATTACHMENT A
Sliding Fee Scale / Self-Declared Form

Completion of this form is necessary in order to apply for Health First CHC Sliding-Fee Scale Discount Program for today's visit when proof of income documentation/verification is unavailable. Self-declare can only be done once within 365 days.

The information contained in this form is strictly confidential and used for administrative purposes only. It is not a part of your medical record, and it is not used for reporting census, immigration or any other documentation. It is used solely to determine your unverified eligibility for the Sliding-Fee Scale Discount for today's visit only.

Patient ID#
«patientid»

Patient's Name:
«ptname»

SS#:
«ptssn»

Total Number of Household Members:	**Total Household Income:**
_____	_____ ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly**

I hereby submit to Health First CHC my unverified income information to be used to determine my eligibility for the Sliding Fee Scale. I understand that this only applies to today's visit only and will not be allowed to self-declare again until a year from today. I understand that the unverified information I supply on this Self-Declared Form does not guarantee that I will qualify for the same Sliding-Fee Scale Discount for future visits when my information is verified.

I have been given a Sliding-Fee Application, which I will complete and submit to Health First CHC along with my proof of income in order to apply for the Sliding-Fee Scale Discount for any future visits.

Patient/Guarantor Signature: _____ Date: _____

For Office Use Only:

Eligible for Sliding Scale: ☐ Class A ☐ Class B ☐ Class C ☐ Class D ☐ Not Eligible

Self-Declared Set Up in System? Yes or No

Staff Signature:_____ Date:_____

Sliding Fee Discount Income Verification Guidelines ATTACHMENT B

Please complete Sliding Fee Discount Application entirely, sign application and return application and income information to the outreach department.

Discounts are based on family size and income only.

Family: Include all family members related by birth, marriage or adoption and residing together including other relative living in the household such as grandmother, grandchild, aunt, uncle, etc.

Income: Include earnings, unemployment and/or workers compensation, Social Security, Supplemental Security Income (SSI) public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rent income, royalties, alimony, and child support.

You must provide at least one of the following:

- Prior year W-2.
- Two most recent pay stubs.
- Letter from employer that must include employer's name, address and phone number.
- Form 4506-T (if W-2 not filed).
- Form 1040 or 1040A.
- Social Security letter for fixed incomes such as social security, disability, pension, etc.
- Snap benefits letter from food stamp office.
- Unemployment compensation documentation.
- Letter of reference from any 501(c) (3) non-profit organizations such as homeless shelters or churches.
- Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business.

Return application and proof of income to the Outreach Department before or at the next visit. Discount will starts on the day the completed application and proof of income is returned and approved. Discounts are good one year unless financial situation changes significantly.

We will contact you in writing if you are denied for any reason. If approved we will send you a slide card with Slide Class that is assigned. Please show the slide card to the receptionist at each visit.

If your application is approved, outreach specialists will work with medical staff, pharmaceutical companies and local community resources to help provide medical and social needs that you may need. Outreach workers will use information from application and income verification to apply to additional assistance.

Sliding Fee Discount Application
ATTACHMENT C

It is the policy of Health First CHC to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including laboratory testing done at other facilities, test ordered by outside providers, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD			**Date of Birth**	
STREET	**CITY**	**STATE**	**ZIP**	**PHONE**
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□Wkly □ Bi-Wkly □Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**
Dependents			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**

Dependent			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**

NOTE: Copies of tax returns, pay stubs, or other information verifying income ARE required before a discount is approved.
I certify that the family size and income information shown above is correct. I understand that Outreach workers may use my application information and income verification to help me with additional medical and social needs such as obtaining free medicine from pharmaceutical companies or food banks.

Name (Print) _____

Signature _____ Date _____

Office Use Only

Income	**Amount**	**Rate**	**Total Income**
		Annual: X 52 Wkly, X 24 Bi- Mthly, X 26 Bi-Wkly, X 12 Mthly, X 1 Annual Monthly Rate: X 4 Wkly, X 2 Bi-Wkly	
		Annual: X 52 Wkly, X 24 Bi- Mthly, X 26 Bi-Wkly, X 12 Mthly, X 1 Annual Monthly Rate: X 4 Wkly, X 2 Bi-Wkly	
		Annual: X 52 Wkly, X 24 Bi- Mthly, X 26 Bi-Wkly, X 12 Mthly, X 1 Annual Monthly Rate: X 4 Wkly, X 2 Bi-Wkly	
		Total Household Income	

Discount applied to patients:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Alternative Payment Source (Medicare/Medicaid) applied for? Yes No Refused

Income verified by proof of income? Yes No

Approved Discount Class Assigned: _____

Approved by: _____ _____ Date Approved/Effective: _____

Slide Insurance Setup: Yes No Slide Card Mailed: Yes No

Regional Health Care Affiliates, Inc.

2018 Sliding Fee Schedule –
(Based on 2018 DHHS Federal Poverty Guidelines)
Effective April 1st 2018

Class A
100% or Below Federal Poverty level
$20 Office Visit, all inclusive excluding x-ray
$5 Each x-ray
100% Discount on labs performed by contracted labs

Family Size	Annual	Monthly	Weekly
1	$ 12,140	$ 1,011.67	$ 233.46
2	16,460	$ 1,371.67	$ 316.54
3	20,780	$ 1,731.67	$ 399.62
4	25,100	$ 2,091.67	$ 482.69
5	29,420	$ 2,451.67	$ 565.77
6	33,740	$ 2,811.67	$ 648.85
7	38,060	$ 3,171.67	$ 731.92
8	42,380	$ 3,531.67	$ 815.00
Each Add'l	$ 4,320	$ 360.00	$ 83.08

Class B
150% or Below Federal Poverty level
$40 Office Visit, all inclusive excluding x-ray
$8 Each x-ray
75% Discount on labs performed by contracted labs

Family Size	Annual	Monthly	Weekly
1	$ 18,210	$ 1,518	$ 350
2	$ 24,690	$ 2,058	$ 475
3	$ 31,170	$ 2,598	$ 599
4	$ 37,650	$ 3,138	$ 724
5	$ 44,130	$ 3,678	$ 849
6	$ 50,610	$ 4,218	$ 973
7	$ 57,090	$ 4,758	$ 1,098
8	$ 63,570	$ 5,298	$ 1,223
Each Add'l	$ 6,480	$ 540	$ 125

Class C
175% or Below Federal Poverty level
$60 Office Visit, all inclusive excluding x-ray
$16 Each x-ray
50% Discount on labs performed by contracted labs

Family Size	Annual	Monthly	Weekly
1	$ 21,245	$ 1,770	$ 409
2	28,805	2,400	554
3	36,365	3,030	699
4	43,925	3,660	845
5	51,485	4,290	990
6	59,045	4,920	1,135
7	66,605	5,550	1,281
8	74,165	6,180	1,426
Each Add'l	$ 7,560	$ 630	$ 145

Class D
200% or Below Federal Poverty level
$75 Office Visit, all inclusive excluding x-ray
$25 Each x-ray
25% Discount on labs performed by contracted labs

Family Size	Annual	Monthly	Weekly
1	$ 24,280	$ 2,023.33	$ 466.92
2	32,920.00	2,743.33	633.08
3	41,560.00	3,463.33	799.23
4	50,200.00	4,183.33	965.38
5	58,840.00	4,903.33	1,131.54
6	67,480.00	5,623.33	1,297.69
7	76,120.00	6,343.33	1,463.85
8	84,760.00	7,063.33	1,630.00
Each Add'l	$ 8,640	$ 720.00	$ 166.15