Self-Declared Form
ATTACHMENT A

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. The self-declare form has a grace period of one day in a 365 day period. Once the self-declare is utilized, you will need to complete the application to qualify for the Health Center's Sliding Fee Discount Program.

The information contained in this form is confidential and used for administrative purposes only. This document will be stored in your financial section of your medical record. It is not used for reporting census, immigration or any other documentation purposes. 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. I will not be allowed to self-declare again until a year from today's date. 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 proof of income information is verified.

I acknowledge have been given a Sliding Fee Application. 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. Please sign and return completed application and proof of income information to the health center within 14 days of the initial visit. Discount will start on the day proof of income is received.

Discounts will be based on household size and income. Health First CHC recognizes families do not always fit the traditional model. Health First identifies the definitions of a household, family and income as below:

A. **Household** consists of all the persons who occupy a house or apartment. Adult children living at home who are no longer dependent are considered a separate household. Roommates who share living arrangements but are not tied to one another through marriage, children or similar relationships are considered separate households. Those living with a friend or relative during a time of need, are also considered a separate household.

B. According to the Census Bureau a **family** is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

C. **Income** includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

Patients will not be discriminated based on age, gender, race, creed, disability, national origin or insurance status. Dignity, confidentiality and respect will be given to all who seek and/or are provided charitable services.

You must provide at least one of the following:

- Prior year W-2.
- Two most recent pay stubs.
- Letter from employer stating patient's income. Health First would prefer document be on letterhead and must include employer's name, address and phone number.
- Form 4506-T (if W-2 not filed).
- Form 1040, 1040A or 1040EZ.
- Social Security letter for fixed incomes such as social security, disability, pension, etc.
- SNAP benefits letter
- Free lunch school form, which must include household size and income.
- Most recent unemployment compensation documentation.
- Letter of reference on letterhead from any 501(c) (3) non-profit organizations such as homeless shelters or churches.
- Letter from the patient's medical provider stating patient is unable to work due to health condition, surgery, etc.
- Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business.

We will contact you in writing if you are denied for any reason.

If approved we will send you a slide card identifying your assigned Slide Class. Please show the slide card to the receptionist at each visit. The Outreach Specialists will work with medical staff, pharmaceutical companies and local community resources to help provide medical and social needs, as needed. Outreach workers could utilize information from your application and income verification to apply for additional assistance, as needed.

Sliding Fee Discount Application
ATTACHMENT C

The Sliding Fee Discount Program is designed to provide discounted services to patients who have limited or no means to pay for their medical services. The slide program's intent is to assure that no patient will be denied services due to an individual's inability to pay for services. Discounts will be based on household income and size.

Sliding Fee Discount Program applications cover patient balances incurred within 12 months after the approved application date. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in household size or income.

Please complete Sliding Fee Discount Application entirely. Sign and return the completed application and proof of income information to the health center within 14 days of the initial visit. Discount will start on the day the proof of income is received.

The discount will apply to all in-house services received at this clinic. Outside services such as x-ray interpretation will not be included in the health centers Slide Fee Discount Program. Additional discounts may apply for these services as indicated in the Slide Fee Schedule.

This form must be completed every 12 months or if your financial situation changes.

NOTE: Proof of Income information is required before discount qualification can be processed.

I certify that the household size and income information shown above is correct. I understand that Outreach Specialist may use my application information and income verification to help me with additional medical and social needs, as needed.

Name (Print) _____

Signature _____ Date _____

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**

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.
Attachment D
2018 Sliding Fee Schedule –
(Based on 2018 DHHS Federal Poverty Guidelines)
Effective November 1st 2018

Class A 100% or Below Federal Poverty level $10 Nominal Fee, all inclusive including x-ra 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 $15 Office Visit, all inclusive including x-ray 100% 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 $20 Office Visit, all inclusive including x-ray 100% 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 $25 Office Visit, all inclusive including x-ray 100% 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