|  |
| --- |
|  |

Sliding Fee Scale Discount Application

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | Date: |  |
|  | Last | First | M.I. |  |  |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Birth: |  | Social Security No.: |  | Do you have insurance? |  |

|  |  |
| --- | --- |
| Marital Status: | Single / In a relationship / Married / Divorced / Separated / Widowed |

|  |
| --- |
| **HOUSEHOLD SIZE** |
| **Name** | **Date of Birth** | **Social Security Number** |
|  |   |   |
|  |   |   |
|  |   |   |
|  |   |   |
|  |   |   |
|  |   |   |

Manager Approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **HOUSEHOLD INCOME** |
| **Name** | Amount | Frequency (circle one) | Employer |
| **You** | $ | Weekly / Monthly / Yearly |   |
| **Spouse** | $ | Weekly / Monthly / Yearly |   |
| **Children** | $ | Weekly / Monthly / Yearly |   |
| **Other** | $ | Weekly / Monthly / Yearly |   |
|  | $ | Weekly / Monthly / Yearly |   |
| **TOTAL** | $ | Weekly / Monthly / Yearly |   |
|   |  |  |  |  |  |   |
| Other Income | You | Spouse | Children | Other | Subtotal |
| **Social Security** |   |   |   |   |   |
| **Public Assistance** |   |   |   |   |   |
| **Retirement Pension** |   |   |   |   |   |
| **Child support, Alimony** |   |   |   |   |   |
| **Interest Income** |   |   |   |   |   |
| **Other** |   |   |   |   |   |
|  |   |   |   |   |   |
|  |   |   |   | TOTAL | $ |
|  |  |  |  |  |  |

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and completely confidential. You must verify your income at least every year. Please bring yearly income tax return, copy of your W-2 form, last month’s paycheck stubs, copies of your social security checks, or other checks you may receive as proof of family income.
 \*Income verification and application is not required if you know you will qualify at 200% or over.

All patients seeking healthcare services at Astria Health Centers are assured that they will be served regardless of ability to pay. No one is refused service because of lack of financial means to pay.

Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for clinic visits. Information and forms can be obtained from the Front Desk and the Business Office.

Alternative payment sources: All alternative payment resources must be exhausted, including all thirdparty payment from insurance(s), Federal and State programs.

The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize Astria Health Center’s access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the date on their application adjusted. If a patient does not provide the requested information within the two week time period, their application will be re-dated to the date on which they supply the requested information. Any accounts turned over for collection as a result of the patient's delay in providing information will not be considered for the Sliding Fee Discount Program.
Discounts will be based on income and family size only. Astria Health Center’s use the Census Bureau definitions of each.

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.

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.

#

# Sliding Fee Schedule

|  |
| --- |
| **Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty** |
| **Poverty Level \*** | **At or****Below 100%** | **125%** | **150%** | **175%** | **200% & Above** |
| **Family Size** | **Nominal****Fee $10.00** | **20% Pay** | **40% Pay** | **60% Pay** | **70% Pay** |
| 1 | 0-$12,140 | $12,141- $15,175 | $15,176-$18,210 | $18,211-$21,245 | $21,246+ |
| 2 | 0-16,460 | $16,461- $20,575 | $20,576-$24,690 | $24,691- $28,805 | $28,806+ |
| 3 | 0-$20,780 | $20,781-$25,975 | $25,976-$31,170 | $31,171-$36,365 | $36,366+ |
| 4 | 0-$25,100 | $25,101-$31,375 | $31,376--$37,650 | $37,651-$43,925 | $43,926+ |
| 5 | O-$29,420 | $29,421-$36,775 | $36,776-$44,130 | $44,131-$51,485 | $51,486+ |
| 6 | 0-$33,740 | $33,741-$42,175 | $42,176-$50,610 | $50,611-$59,045 | $59,046+ |
| 7 | 0-$38,060 | $38,061-$47,575 | $47,576-$57,090 | $57,091-$66,605 | $66,606+ |
| 8 | 0-$42,380 | $42,381-$52,975 | $52,976-$63,570 | $63,571-$74,165 | $74,166+ |
| For each additional person add | $4,320 | $5,400 | $6,480 | $7,560 | $8,640 |

\*Based on 2018 Federal Poverty Guidelines (<http://.hhs.gov/poverty>)

## Disclaimer and Signature

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Astria Health Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Astria Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_