



- Anderson Creek Dental Center
- Anderson Creek Medical Center
- Angier Medical Center

- Benhaven Medical Center
- Boone Trail Medical Center
- Mobile Unit (Dental / Medical)

SLIDING FEE APPLICATION

Name: _____ DOB: _____ Chart #: _____

Background of Sliding Fee Discount Program

The Sliding Fee Discount Program is a federal program that permits First Choice Community Health Centers (FCCHC) to discount normal charges for either a medical or dental visit. According to law, it requires two pieces of information in order to qualify: the amount of money earned in the household and the number of people who live in the household. In order to be eligible for the Sliding Fee Scale, you must provide accurate and acceptable proof of income as well as list all persons within the household within **10 business days** of the date you signed this application or you will be responsible for 100% of all charges. You must report any changes in family income or number of members in the household when these changes occur. Falsification of this information will result in forfeiture of Sliding Fee Scale privileges and possible release from the practice as it is a violation of Federal Law.

Eligibility

All FCCHC patients are eligible to apply for the slide. Determination of the discount, if any, is dependent upon household income and household size in comparison to the current Federal Poverty Guidelines. The discount may apply to Insurance / Medicare deductibles as well as non-covered services. **The discount does not apply to insurance co-pays.**

Term

Information must be updated every twelve (12) months or with any change of household income or household size.

Definitions and Examples of Acceptable Proof Required

Income Determination

1. Income is based on the **gross income** of all household members earning income.
Income used to compute poverty status:
 - 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.
 - Before taxes.
 - Excludes capital gains or losses.
 - If a person lives with a family, add up the income of all members in the household.
2. Acceptable forms of proof for determining income include the following.
 - a. Income Tax Return: A signed copy of the most recent tax return showing Adjusted Gross Income.
 - b. Pay check stubs: Two or more consecutive pay stubs indicating gross pay within the past thirty (30) days.
 - c. Agency letter: A letter from the Social Security Administration, Veterans Administration or Social Service Agency (i.e., AFDC, Food Stamps, or WIC) indicating income level.
 - d. Unemployment Verification: Paperwork from the Employment Securities Commission (ESC) proving unemployment status and the amount of unemployment compensation being received.
 - e. Court Documents: Official documents citing child support or alimony as awarded by a judge.
 - f. Official Paperwork: Paperwork documenting retirement, disability, SSI benefits.
 - g. Employer Letter: For those not receiving an actual pay check, a letter from the patient's employer detailing current gross income and frequency of pay periods may be accepted. Contact information must be provided so that information can be verified.

Household Size Determination

1. All members of a household who are pooling financial resources including room and board and/or are supporting one another financially are counted as one household.
2. Household size can be documented with any of the following.
 - a. A copy of the most recent tax return showing household size.
 - b. Social Security card
 - c. Birth Certificate
 - d. Medicaid cards for any dependent children
 - e. Driver's License or State ID cards
 - f. Court or government documents that indicate the number of members in household
 - g. Rental agreements or a letter from the landlord that indicates the number of household members. Contact information must be provided so that information can be verified.

(Please fill out the back of this form and sign.)



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Eligibility Determination

TO BE COMPLETED BY PATIENT/GUARDIAN: Please complete ALL your family information below:

							For Internal Use Only	
Name	Family Relation	Date of Birth	ID Number (SSN, DL, etc.)	Income	Frequency W/B/M/Y	Type of Income Documentation	Date All Documentation Received	Documentation Received By

*****Documentation must be provided by patient or guardian to determine eligibility for Sliding Fee Scale*****

I understand that the information I provide on this form is subject to verification by First Choice Community Health Centers. I certify that the above information is true and correct to the best of my knowledge and that I understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.

Patient/Guardian Signature

Printed Name

Date

..... (DO NOT write below this line. To be completed by FCCHC.)

Acceptable Income Documentation [Enter (√) if verified and obtained]	Calculated Amount Associated with Documentation
Current Federal Tax return.	
Last 30 days paycheck stubs (Paycheck stubs must be dated within last 30 days, must have employer name, employee name and/or social security number, time frame of payment (number of hours worked per period) and rate of pay. If hours worked and amounts vary an average will be taken for the month)	
Company letter stating annual earnings (Letter must contain a contact person and phone number for contact. This form of proof must be verified by the Healthcare Representative.	
Official Letters / Documents from Social Security, Courts, Child Support, ESC, etc.	
Total Income Amount	

Total Number of Family Members Applying for the Sliding Fee Program _____

Enter (√) if verified and obtained	Verified and Obtained Information
	Acceptable identification for each family member listed on Sliding Fee Program Application.
	All family member(s) name(s) and date(s) of birth listed on Sliding Fee Program Application.

Qualified Poverty Percentage	Medical Slide Category	Dental Slide Category	Slide Effective Date	Slide Termination Date

Signature of FCCHC Staff

Printed Name

Date

FRONT DESK – Scan into patient’s electronic record with all supporting documents.