FIRST CHOICE
Community Health Centers

☐	Anderson Creek Family Dentistry	☐	Benhaven Medical Center
☐	Anderson Creek Medical Center	☐	Lillington Health Center
☐	Angier Medical Center	☐	Mobile Unit (Dental/Medical)

SLIDING FEE REQUIREMENTS

The following items are **REQUIRED** to apply for the Sliding Fee Scale that reduces the cost of health care through First Choice Community Health Centers.

1. Income Verification	Provide all applicable documents from the Income Determination section of the application.
2. Household Size Verification	For each member of the household, provide one document from the Household Size Determination section of the application.
3. Identification Determination	The applicant must provide a government issued picture ID.

** Please turn in your application with **ALL** required items attached. **

IF YOU DO NOT have **ALL** of the items above **YOUR REQUEST WILL BE POSTPONED UNTIL YOU HAVE SUBMITTED ALL REQUIRED DOCUMENTATION. DELAYS IN SUBMITTING YOUR DOCUMENTS MAY CAUSE YOUR REQUEST TO BE DENIED.**

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

Approved: *Sheila Simmons 12-19-2017* Revised: 02/14/2018

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SLIDING FEE APPLICATION

Name: _____ DOB: _____

Sliding Fee Program
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 to qualify in order to qualify: the amount of money earned in the household and the number of people who live in the household. To be eligible for the Sliding Fee Scale, you must provide accurate and acceptable income as well as list all persons within the household as of the date that you signed this application or you will be responsible for 100% of all charges. You must report any change in family income or number of members in the household when 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-pay.**

Term
The information should be updated every twelve (12) months or with any change in income of household or the size of the household.

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:
   a. Includes earnings, unemployment 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 of the household, and other miscellaneous sources.
   b. Non-cash benefits (such as food stamps and housing subsidies) do not count.
   c. Before taxes.
   d. Excludes capital gains or losses.
   e. 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. Paycheck Stubs: Two or more consecutive paystubs 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 the retirement, disability, SSI benefits.
   g. Wage Verification Form: For those not receiving an actual pay check.

Household Size Determination:

1. All the members of a household who pooling financial resources including room and board and/or they 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 the 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.

Identification Determination: Form of government-issued picture identification.

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(TO BE COMPLETED BY PATIENT / GUARDIAN: Please complete ALL information of the family:)

Eligibility Determination

							For the use internal only	
Name	**Family Relation**	**Date of Birth**	**List all health insurance plans by which you are covered**	**Income**	**Frequency W/B-W/M/Y**	**Type of Income Documentation**	**Date All Documentation Received**	**Documentation Received By**

***** Documentation must be provided by patient or guardian to determine eligibility of 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 the terms and conditions of the program 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 Security Social 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).	
	Wage verification form completed by employer.	
	Official Letters / Documents from Social Security, Courts, Child Support, ESC, etc.	
	Total Income Amount:	

Total number of family members who apply for the program fee sliding	
Enter (□) if verified and obtained	**Information verified and obtained**
Acceptable identification for each family member listed on Sliding Fee Program Application.	
All family member names and dates 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**

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SLIDING FEE ACKNOWLEDGEMENT FORM

Patient Name: _____ DOB: _____ Patient Account Number: _____

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 as 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.

All FCCHC patients are eligible to apply for the Sliding Fee Discount Program. 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.** Eligibility and household requirements are specifically outlined on our Sliding Fee Application. Sliding fee discounts will be honored for households that fall below 200 % of the Federal Poverty level. Proof of income and household size determines what percentage you may be eligible for.

Below are the five levels for the *Medical* Sliding Fee Discount Program:

• **< 100% of the Federal Poverty Level -**	Qualifies for a nominal fee of $25.00 for entire medical visit.
• **> 100% - 150% of the Federal Poverty Level**	Qualifies to pay 25% of total bill for entire medical visit.
• **> 150% - 175 % of the Federal Poverty Level**	Qualifies to pay 50% of total bill for entire medical visit.
• **> 175% - 200% of the Federal Poverty Level**	Qualifies to pay 75% of total bill for entire medical visit.
• **> 200% of the Federal Poverty Level**	Qualifies for no discount. Responsible for 100% of entire medical bill.

Below are the four levels for the *Dental* Sliding Fee Discount Program:

• **< 100% of the Federal Poverty Level**	Qualifies for a nominal fee of $35.00 for each basic dental service. Must pay 25% for all expanded dental services.
• **> 100% - 175% of the Federal Poverty Level**	Qualifies for a nominal fee of $35.00 for each basic dental service. Must pay 50% for all expanded dental services.
• **> 175% - 200 % of the Federal Poverty Level**	Qualifies for a nominal fee of $35.00 for each basic dental service. Must pay 75% for all expanded dental services.
• **> 200% of the Federal Poverty Level**	Qualifies for no discount. Responsible for 100% of entire dental bill.

My signature below acknowledges that I have been provided with and understand the Sliding Fee Discount Program and that it is my responsibility to provide the necessary income and household documentation to qualify for and be eligible for the any sliding fee discount according the federal poverty levels provided above.

_____	_____	_____	_____
Medical Slide%	Dental Slide%	Sliding Effective Date	Sliding Fee Termination Date

_____	_____
Documentation Missing to Qualify for Sliding Fee Program	Date to Return By

_____	_____	_____
*Patient/Responsible Party Printed Name	Patient/Responsible Party Signature	Date

FCCHC Staff Signature: _____ Date: _____

Approving Authority: _____ Date: _____

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