



# Procedure or Protocol

The Sliding Fee Discount Program is offered based on household income and number of persons in the household.

**Discounted services include medical services, dental services, behavioral health services, substance use disorder group services, physical and occupational services and pharmacy prescription medications provided at the Family Health Center, Inc.**

**Family Health Center, Inc. will collect a minimum payment at the time of service. Please be aware that the balance will be billed to you after services are provided.**

Intrauterine device (IUD), implantable contraceptive, hormone injections and dental lab expenses, i.e. third party fees associated with dental procedures, including but not limited to laboratory fees associated with crowns and dentures are non-eligible for the sliding fee discount program. If you have further questions, please contact the Patient Accounts Department.

You must complete a sliding fee discount program application, and attach proof of income. If the proof of income presented does not belong to the patient, the person or persons in the household must appear with picture identification during the application process. **If you do not have proof of income during the visit, you have 30 days to complete and return this information. Otherwise you will not receive the discount and will be responsible for**

**FULL charges. The 30-day waiver will be honored on the day of the patient’s visit for prescriptions written by FHC providers.**

Proof of income can be two bi-weekly paycheck stubs, four weekly paycheck stubs, social security benefits statement, unemployment benefit statement or any source of income. If you do not have income, it is possible to use unemployment office documentation, or an acceptable letterhead from a pastor/minister stating that you are unemployed and do not have any income.

Sliding fee discount certification is completed once per year. Patients are required to notify the Family Health Center, Inc. of any changes in income.

---

**I have read and understand the sliding fee discount program information. I understand that:**

- 1. Family Health Center, Inc. will collect a minimum payment at the time of service.**
- 2. The balance will be billed to me after services are provided.**
- 3. I must complete the sliding fee discount program application, and attach proof of income with picture identification.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

|                                   |                                    |
|-----------------------------------|------------------------------------|
| 67.1 Sliding Fee Discount Program | Page 5 of 14                       |
| Author(s): Eileen Chiang          | Officer Approval Date: August 2020 |
| Reviewed By: Eileen Chiang        | Review Date: January 2021          |



# Procedure or Protocol

## SLIDING FEE DISCOUNT PROGRAM APPLICATION (Page 1 of 3)

The Family Health Center, Inc. offers the sliding fee discount program for persons earning between 0% to 200% of the federal poverty level. Please complete the application and provide identification to determine eligibility for the program.

Patient Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Responsible Party: \_\_\_\_\_  
(If different from patient) (Last) (First) (Middle Initial)

Responsible Party Date of Birth: \_\_\_\_\_ SSN # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I certify the information in this application is true. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee discount program and will subject me to penalties under Federal Laws. If acceptance to the sliding fee discount program is obtained under this application, I will comply with all rules and regulations of Family Health Center, Inc.

Responsible Party Name: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

|                                   |                                    |
|-----------------------------------|------------------------------------|
| 67.1 Sliding Fee Discount Program | Page 6 of 14                       |
| Author(s): Eileen Chiang          | Officer Approval Date: August 2020 |
| Reviewed By: Eileen Chiang        | Review Date: January 2021          |



# Procedure or Protocol

## SLIDING FEE DISCOUNT PROGRAM APPLICATION (Page 2 of 3)

Number of Persons in Household: \_\_\_\_\_

| <u>Name</u> | <u>Date of Birth</u> |
|-------------|----------------------|
| _____       | _____                |
| _____       | _____                |
| _____       | _____                |
| _____       | _____                |
| _____       | _____                |
| _____       | _____                |
| _____       | _____                |
| _____       | _____                |
| _____       | _____                |
| _____       | _____                |

Responsible Party Name: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

|                                   |                                    |
|-----------------------------------|------------------------------------|
| 67.1 Sliding Fee Discount Program | Page 7 of 14                       |
| Author(s): Eileen Chiang          | Officer Approval Date: August 2020 |
| Reviewed By: Eileen Chiang        | Review Date: January 2021          |

# Procedure or Protocol

## SLIDING FEE DISCOUNT PROGRAM APPLICATION (Page 3 of 3)

This section to be completed by Family Health Center staff.

| Type of Income (Attach proof of income)                                      | Income Calculations |
|--|---------------------|
| Wages, Salaries, Commission or Fees (check stubs, federal income tax return) |                     |
| Social Security or disability payments                                       |                     |
| Public Assistance  |                     |
| Unemployment Benefits  |                     |
| Government Pension or Veteran Benefits                                       |                     |
| Alimony or Child Support   |                     |
| Other Income   |                     |
| <b>Total Annual Income</b>   |                     |

**No income:** Unemployment office documentation

Acceptable letterhead from a pastor/minister

Other documentation (Specify: \_\_\_\_\_)

| Sliding Fee Discount Category (refer to pages 11-14 for SFD schedule) | A    | B   | C   | D   |
|---|------|-----|-----|-----|
| % visit charges to be billed (Medical):                               | \$15 | 25% | 35% | 50% |
| % visit charges to be billed (Dental):                                | \$25 | 25% | 35% | 50% |
| % visit charges to be billed (BH):                                    | \$25 | 25% | 35% | 50% |
| % visit charges to be billed (PT/OT):                                 | \$25 | 25% | 35% | 50% |
| % visit charges to be billed (Group)                                  | \$15 | 25% | 35% | 50% |

Certified by: \_\_\_\_\_

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

This application is active **From:** \_\_\_\_\_ **To:** \_\_\_\_\_

(After initial certification, date for Recertification is One Year with income)

**I have read and understand the sliding fee discount program information. I understand that:**

1. Family Health Center, Inc. will collect a minimum payment at the time of service.
2. The balance will be billed to me after services are provided.
3. I must complete the sliding fee discount program application, and attach proof of income with picture identification.

Responsible Party Name: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

|                                   |                                    |
|-----------------------------------|------------------------------------|
| 67.1 Sliding Fee Discount Program | Page 8 of 14                       |
| Author(s): Eileen Chiang          | Officer Approval Date: August 2020 |
| Reviewed By: Eileen Chiang        | Review Date: January 2021          |