STOP

PLEASE READ BEFORE COMPLETEING APPLICATION

Please fill out application completely. Failure to do so may result in delay of processing. Do not leave any areas blank. If a question or area on the application does not apply to you, indicate so by place (N/A) in the designated location. Please print clearly.

If you are re-applying: failure to return ALL required documentation will result is termination of the Slide Program and any balance on your account will be due immediately. No further credit will be allowed to accumulate on your account until the past due balance is paid.

If you are a NEW patient: ALL supporting documentation is due at the time of service. If all documentation is not provided, you will be self-pay and your application will not be processed.

Stony Creek Community Health Center

Sliding Fee Discount Program Policy

Listed are the following guidelines for applying for the Slide Fee Discount Program at Stony Creek Community Health Center. New and returning applicants must return the application and "ALL" required documentation before their appointment; otherwise, you will considered SELF_PAY and expected to pay for services in "FULL" or reschedule your appointment. *APPLICATIONS ARE NOT RETROACTIVE.*

1. **Notification:** SCCHC will notify patients of the Sliding Fee Discount Program by placing notification in clinic waiting area
2. **Request for discount:** Available to patients experiencing financial hardship. If approved, discounts will only apply to services provided at SCCHC. Applications may be obtained at the ***FRONT DESK.***
3. **Administration:** Dignity and confidentiality will be respected for all who seek and/or are provided charitable services.
4. **Alternative payment source:** All eligible payment resources must be exhausted. Health insured applicants may still be eligible to participate in the Slide Fee Discount Program.
5. **Completion of Application:** The Slide Fee Application must be completed in its entirety. By signing, you authorize SCCHC access to verify income disclosed on the application. Providing false information will result in termination from the program and any outstanding balances shall become payable immediately.
6. **Eligibility:** Discounts will be based on family size only. SCCHC uses the **Census Bureau** definitions of each.
   a. **Family:** mother, father, dependent children, related by marriage, adoption and residing together; all such people (**including related subfamily members**).
   b. **Income includes:** gross earnings, unemployment compensation, worker's 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 household, and other miscellaneous sources. Bank statements showing direct deposits and official award letters are acceptable forms of proof for Social Security/Retirement income. Noncash benefits (**such as food stamps (SNAP**) and housing subsidies) do not count.
7. **Income verification:** one of the following: W-2/Federal Income ***OR*** Tax return, ***AND*** two most recent pay stubs or a letter from employer. Self employed applicants (3 months income/expense history). Self declaration of income may only be used in special circumstances and are responsible for 100% of their charges until management determines the appropriate category.
8. **Record keeping:** Information related to Sliding Fee Discount Program determination will be maintained and preserved in a centralized file located in the office, in an effort to preserve the dignity of those receiving free or discounted care.
9. **Policy and procedure review:** Annually, the amount of Sliding Fee Discount Program provided will be reviewed by the Director. The SFS will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing amount budgeted and actual community care provided shall serve as a guideline for future planning.

Stony Creek Community Health Center

Sliding Fee Discount Program Application

<u>Policy for Sliding Fee Discount Program</u>
It is the policy of Stony Creek Community Health Center (SCCHC) to provide essential medical services regardless of the patient's ability to pay. Discounts, made possible through a federal grant, are offered depending on household gross income **(before any deductions)** and family size. A family member is the mother, father and dependent children under 18. Dependent children who are over 18 years of age and full-time students must provide proof of enrollment, class schedule, etc. Other adults in the household are considered separately.

A sliding fee schedule is used to calculate the basic discount and is updated each year using current federal poverty level (FPL) guidelines.

Slide A	**$15.00**	**0% - 100% FPL**
Slide B	**$25.00**	**101% - 150% FPL**
Slide C	**$35.00**	**151% - 175% FPL**
Slide D	**$45.00**	**176% - 200% FPL**

Any changes in household income and/or family size must be reported to SCCHC immediately as this may change continuing eligibility and/or the discount amount. Once approved, the discount is honored for one year from the approval date, after which the head of household must re-apply.

New and returning applicants must return the application and all required information before their appointment otherwise you will be required to pay for services in FULL. Discount is not retroactive.

<u>Discount Application Process</u>
An application form must be completed in its entirety and proof of income received before being reviewed. Acceptable proof of income consists of:

<u>Employed Applicants</u>: Last two (2) concurrent pay stubs showing gross income **and** copy of current Federal income tax return **or** W-2.

<u>Self-Employed Applicants</u>: Most recent federal income tax return.

<u>Unemployed-No Income Applicants:</u> 1.) Notarized (by a Notary Public) "Statement of Support" must be provided and signed by whomever furnishes you a place to live, buys food, or pays your bills and/or a 2) Notarized statement that you have no earnings income but live off your savings listing the amount withdrawn each month to pay expenses.

<u>Government Benefits:</u> Social Security, SSI, Disability or other government benefits-Proof of income by way of S.S. benefit statement (sent annually in January) showing amount of monthly benefit OR copy of most recent check(s), OR bank statement showing automatic deposit amount.

<u>Social Services:</u> Housing/Food Stamps: Letters of monthly amounts, approval, denial, or pending status from your local department of Social Services.

<u>Other Resources:</u> Bank statement or official award letter or retirement benefits, Relief Aid to Dependent Children, TANF, trust fund allotments, and funds from child support and/or alimony, rental property and rent money someone pays to live with you.

<u>Covered/excluded Services:</u> The discount is applied to all **in-office** services including **in-office** laboratory services and X-ray services except **Sports Physicals, Drug Testing and Depo-Provera injections.**

Your heath care policy will be reduced to the lesser of the two if you have health insurance and qualify for the Sliding Fee Discount Program. Ex: if your health insurance has a co-pay of $25.00 and you qualify for a discount of $15.00, then $15.00 is what you would be expected to pay at the time services are rendered.

Stony Creek Community Health Center
12454 Hartley Street, P.O. Box 188, Stony Creek, VA 23882 Phone: (434) 246-6100 Fax: (434) 246-6614

Name: ______________________ Address: ______________________ City/State/Zip: ______________________

Phone #: ______________________ SSN: ______________________ DOB: ______________________

Marital Status: ___ Single ___Married ___Divorced ___Widowed ___ Legally separated (must provide documentation and/or Notarized statement)

Do you have medical insurance? ___Yes ___No ***** If you check (yes) to this question, you must provide a copy of the insurance card (this does not mean that you will not qualify for the program; however, the facility is required to bill your carrier for services.

Eligibility Determination

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

NAME	RELATIONSHIP	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER

Annual GROSS Household ***Income*** (NET: before taxes)

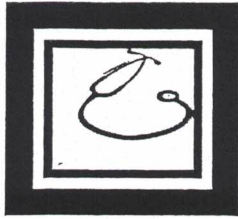
Employment Wages: $	SSI: Retirement Benefits: $	SSI: Disability Income: $	Unemployment Benefits: $	TANF (Aid to Dependent Children): $
Alimony: $	Child Support (You receive): $	Rental Income (You receive): $	Veteran's Benefit: $	Trust Fund Income: $
Retirement or Pension/Annuities: $	Liquid Assets (Savings, Investment Income): $	Side-Line Income: $	Farm Income: $	Seasonal Income: $
OTHER (Specify): $				

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

Applicant Signature: ______________________ Printed Name: ______________________ Date: ______________________

******************(DO NOT WRITE BELOW THIS LINE. TO BE COMPLETED BY SCCHC)******************

Medical Slide Category: (Circle One)	**Application responsibility: (Circle one)**	**Slide Effective Date:**	**Slide Termination Date:**
A B C D	$15 $25 $35 $45		
Approved by:			



Stony Creek Community Health Center

12454 Hartley Street, Stony Creek, VA 23882 Ph: (434) 246-6100 Fax: (434) 246-6144

(Statement of Support)

I, ______________________________, am providing assistance with daily living expenses for______________________________ (**applicant**) during the time that he/she is without monetary income.

______________________________ ______________________

Signature of Supporter Date

(Certificate of Acknowledgement of Notary Public)

COMMONWEALTH OF VIRGINIA COUNTY OF ______________________________

This document acknowledged before me on ______________________________ (date) by

______________________________ (name of Notary).

____

Signature of Notary Officer

Notary Public for the Commonwealth of Virginia

My Commission Expires: ______________________________

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THAT FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.