FamilyCare HEALTH CENTERS

SLIDING FEE SCALE APPLICATION

- ☐ **Are you 19 years of age or older?**
- ☐ **Are you 64 years old or younger?**
- ☐ **Do you have a Medicaid or Medicare red white and blue card?**
- ☐ **Do you receive Social Security benefits?**

You may qualify for additional services if you are under 19 or over 65 or if you receive Social Security benefits. If you receive Medicaid, you do not qualify for the Sliding Fee Scale program. If you receive Medicare, it is still a possibility that you qualify for discounted services in addition to your Medicare card.

Please check any items below that you receive or have recently applied for:

- ☐ EBT Card (SNAP benefits) from the DHHR
- ☐ Court ordered child support
- ☐ Retirement
- ☐ Unemployment
- ☐ Workers' Compensation
- ☐ Welfare Assistance (financial or utilities)
- ☐ Housing Assistance
- ☐ Financial Assistance from a family member or a friend
- ☐ Social Security or Social Security Disability

*** If you receive ANY of the above items, you must provide verification of this income.** Example: If you receive SNAP benefits, we will need verification with the amount from the DHHR. For child support, we require the current statement from child advocate or your court order. If you are unsure of what to bring in as proof, please ask for assistance from the Outreach Coordinator or an office staff member. **If you do not provide us with this information, your application will be considered incomplete and will NOT be processed!**

Please attach your proof of income to your application. If you need copies of your original documents, please see a FamilyCare staff member to copy them for you. We will need at least one of the following for proof of income for EVERYONE who receives ANY type of income in the home.

- 90 consecutive days of pay stubs (6 pay stubs if you are paid every two weeks, 12 pay stubs if you are paid every week)
- Most Current Social Security Awards letter
- A letter from your employer on company letter head stating your start date of employment, your hourly rate and the amount of hours you average per week
- A copy of your most recent 1040 tax form from where you filed your taxes. We CANNOT use W2's! Please include your schedule C form if you are self-employed. If you or your family members do not file taxes then we will need the 4506T form that is attached to this application completed and returned to us.

FamilyCare Health Centers
Attn: Angela Hughes
97 Great Teays Blvd., Suite 6
Scott Depot, WV 25560-9816

FamilyCare HEALTH CENTERS

SLIDING FEE SCALE APPLICATION – MEDICAL AND DENTAL

Date _____

Total Number of people in your household (living in your home) _____

First Name, Middle Initial, Last Name	Date of Birth	SS Number	Monthly Income
1._____	___/___/____	_____ (Patient only)	$_____
2._____	___/___/____		$_____
3. _____	___/___/____		$_____
4. _____	___/___/____		$_____
5. _____	___/___/____		$_____
6. _____	___/___/____		$_____
7. _____	___/___/____		$_____

*** Income is money earned before taxes (gross income), self-employment income, alimony, child support, retirement, Social Security (SSI), unemployment, Worker's Compensation, interest from savings, dividends from investments, rental income, seasonal employment income, welfare assistance, SNAP benefit amount from the DHHR, financial assistance from a family member, or any other source of money your family uses to live on. Please include proof of income for the entire household. We must receive 90 days PROOF OF INCOME in order to process your application. Please provide us with your 1040 tax form for the previous year or 90 days of pay stubs.**

This information is true, correct, and complete to the best of my knowledge and belief.

Signature _____

Mailing Address (Street) _____

(City/State) _____ (Zip) _____

Telephone _____ Emergency Contact Phone _____ Name _____

Business Office Use Only - Please Do Not Write in This Space

in Household _____ Gross Monthly Income $ _____ Circle Discount: Nominal Fee 75% 50% 25%
Effective Date _____ Expiration Date _____ Reviewed by _____

Approved for: Sliding Fee Scale □ Yes □ No Entered in: □ Athena

FamilyCare HEALTH CENTERS

SLIDING FEE SCALE PROGRAM AGREEMENT

I agree that the following has been explained to me and that I will follow ALL the guidelines of this program:

1) FamilyCare staff will review your application and let you know if you are eligible for the Sliding Fee Scale program. Your enrollment is generally good for one year with the exception of patients with zero income. If you have no income at this time, your enrollment may expire in less than one year.

2) Only services that are medically necessary and ordered by staff of FamilyCare are covered under this program.

3) Services that are paid for by other programs such as CHIP (Children's Health Insurance Program), Family Planning, Breast and Cervical Cancer Screening program (BCCSP), Medicaid, and any other program are not covered under this program.

4) Employment, camp, school and sports physicals are not covered under this program.

5) Some in-office procedures may not be covered by this program. If the service is not covered, the billing staff will assist you to make payment arrangements.

6) Only laboratory services that are performed in our office are covered under this program. Some lab specimens are collected at our office but sent to an outside lab for processing. These services may or may not qualify for a sliding fee. Please check with a FamilyCare staff member if you have any questions regarding the coverage of any service before it is provided.

7) Charges billed by a hospital or by a health care provider who is not part of FamilyCare are not covered under this program. Dental lab fees (for dentures, etc.) are not covered under this program.

8) Payment of Sliding Fee Scale fees are expected at the time service is received. A pay agreement may be set up if the patient is unable to pay the balance on the day of the visit.

- **I agree to bring my Sliding Fee Scale program card with me to every office visit.**
- **I agree to let FamilyCare know if my income or household size changes before it is time to renew my application.**
- **I understand that I must bring in all documentation of proof of income for the entire household within 30 business days of services rendered or I will be billed full price for services already received.**
- **I understand that FamilyCare staff has the right to ask for proof of income at any time during my participation in this program.**

Signature _____ Date _____

Print Name _____