

# Lincoln Community Health Center, Inc.

## SLIDING FEE APPLICATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_  
(Office Use Only)

### Sliding Fee Discount Program

The Sliding Fee Discount Program is a federal program that permits Lincoln Community Health Center to discount normal charges for a medical 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 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 Lincoln Community Health Center 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 approved 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.
  - a. Income used to compute poverty status:
    - b. 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.
    - c. Noncash benefits (such as housing subsidies) do not count.
    - d. If a person lives with others, 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. Agency letter: A letter from the Social Security Administration, Veterans Administration or Social Service Agency indicating income level.
  - c. Unemployment Verification: Paperwork from the Employment Securities Commission (ESC) proving unemployment status and the amount of unemployment compensation being received.
  - d. Official documents citing child support or alimony as awarded by a judge.
  - e. Official Paperwork: Paperwork documenting retirement, disability, SSI benefits.
  - f. Wage Verification Form completed by employer.

#### 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.

#### Identification Determination

1. Form of government-issued picture identification
2. Verification of location of household/residence (i.e. utility bill, mortgage statement or lease)

Complete and sign the attached application

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### Eligibility Determination

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

Name	Relation	Date of Birth	Income	Frequency	Type of Income Documentation	List all health insurance plans by which you are covered	Annual Deductible
Example: John Doe	Self	5/16/46	\$346	weekly	Tax Form	Medicare	None

**\*\*\*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 Lincoln Community Health Center. I certify that the above information is true and correct to the best of my knowledge and that I understand & agree that providing false information can result in me being denied ability to apply for the program; furthermore I agree to adhere to all terms and conditions of the Sliding Fee Discount Program. **I also understand that I must supply proof of income before receiving any additional services, or I will have to pay the full price for those services with no discount.**

\_\_\_\_\_  
 Patient/Guardian Signature Printed Name Date

..... (DO NOT write below this line. To be completed by Lincoln Community Health Center employee.) .....

Acceptable Income Documentation [Enter (x) if verified and obtained]	Calculated Amount Associated with Documentation
<input type="checkbox"/> Current Federal Tax Return	
<input type="checkbox"/> Wage verification form completed by employer	
<input type="checkbox"/> Official Letters/documents from Social Security, Courts, Child Support, ESC, etc.	
<b>Total Income Amount</b>	

**Total Number of Family Members Applying for the Sliding Fee Program** \_\_\_\_\_

Enter (x) if verified and obtained	Verified and Obtained Information
<input type="checkbox"/>	Acceptable identification for each family member listed on Sliding Fee Program Application
<input type="checkbox"/>	All family member(s) name(s) and date(s) of birth listed on Sliding Fee Program Application.

Sliding Fee Category	Sliding Effective Date	Sliding Termination Date

I certify that all information provided has been reviewed and is complete to the best of my knowledge.

\_\_\_\_\_  
 Signature of Health Center Employee Printed Name Date