

SLIDING FEE SCALE INFORMATION

What is the Sliding Fee Scale?

The Sliding Fee Scale is our way of offering medical and dental services at a lower cost to families who meet certain requirements. The scale is divided into different categories based on family size and gross income. Patients pay for services according to where they fall into the scale.

Who can apply?

All patients without insurance are required to complete a sliding fee scale application.

Patients with insurance can still apply for the sliding fee scale. We will submit your bill to your insurance company at the full fee. If it is rejected, applied to the deductible, or paid in part, your balance will be reviewed for possible discounts.

How do I apply?

Request the sliding fee scale application from the receptionist at your office or go to our website at www.fremontchs.org . Click on the “forms” tab to download the application.

What type of income verification or documents will I need?

All patients must submit a copy of their current year tax return (1040) or complete a form 4506-T (available at our offices.)

In addition, if you are receiving Social Security, Disability, or Pension benefits, you will be required to submit a statement from these agencies verifying amount of benefits being received.

W-2 forms are NOT accepted as proof of income. Proof of income must be received within 30 days of signing the sliding fee scale application. Discounts will only go back 60 days from the date your application is approved.

How long is my application good for?

The **approved** sliding fee scale application is valid for 12 months from April 1st to March 31st . **All sliding fee applicants must reapply after April 1st each year.**

What services WILL be discounted if I'm approved for the sliding fee scale?

- | | |
|-----------------------|---|
| 1. Office Visits | 4. Some lab tests completed by CHS |
| 2. Procedures | 5. Most dental procedures completed in our office |
| 3. Most immunizations | 6. PathLabs may honor your sliding fee discount for some lab services |

What services are NOT covered under the Sliding Fee Scale?

- | | |
|-------------------------|--|
| 1. Pneumococcal vaccine | 3. Adult Tdap vaccine |
| 2. Influenza vaccine | 4. Any services provided at non-CHS facilities including hospitals |

Community Health Services

Sliding Fee Scale Application Valid from April 1, 2008 through March 31, 2009

Please fill out the application completely and attach all income information. Discounts will go back 60 days from the date that the application is approved.

PERSONAL INFORMATION

Last Name: _____ First Name: _____
Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____
Home Address: _____
City/State _____ Zip _____ Phone Number: (Home) (____) ____ - ____
Phone Number: (Cell) (____) ____ - ____

HOUSEHOLD INFORMATION

Name of Spouse: _____
Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____

List Dependents under the age of 18

Name	Social Security No.	Date of Birth	Relationship
_____	____ - ____ - ____	____ / ____ / ____	_____
_____	____ - ____ - ____	____ / ____ / ____	_____
_____	____ - ____ - ____	____ / ____ / ____	_____
_____	____ - ____ - ____	____ / ____ / ____	_____
_____	____ - ____ - ____	____ / ____ / ____	_____

PROOF OF INCOME

You must bring proof of income. () Most Recent Income Tax Return () Form 4506-T
() Social Security/Disability

I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge. ***I also understand a minimum payment of \$20.00 will be requested at the time of each medical office visit and a \$25.00 minimum payment will be requested at the time of each dental office visit.***

Applicants Signature

Date

ELIGIBILITY INFORMATION - FOR OFFICE USE ONLY

Annual Gross Income \$ _____ Number of Dependents _____

Application Approved () 20% Payment (A) () 40% Payment (B)
() 60% Payment (C) () 80% Payment (D)

Application Denied - RESPONSIBLE FOR 100% OF BILL

Processed By

Date