



SLIDING FEE APPLICATION

Date _____

We are pleased to inform you that you may be eligible for a discount of your medical, dental, and behavioral health services today, based on your income. To ensure that we can offer this discount to every eligible patient, we must ensure that those patients ineligible for sliding fee are not receiving an inappropriate discount. With this in mind, we are asking you to fill out and sign the application below. Please tell us your household income. Find the Household Size in the column on the left, then go across that line and circle your annual household gross (before taxes/deductions) income range in the same line; the top of each column of the chart will give you the discount percentage you and your family will receive.

INCOME CHART

Annual Income Thresholds by Sliding Fee Discount

Poverty Level	100%	125%	150%	175%	200%	250%
Household/ Family Size	Nominal Fee \$10	20% Pay	40% Pay	60% Pay	80% Pay	100% Pay
1	12,060	15,075	18,090	21,105	24,120	30,150
2	16,240	20,300	24,360	28,420	32,480	40,600
3	20,420	25,525	30,630	35,735	40,840	51,050
4	24,600	30,750	36,900	43,050	49,200	61,500
5	28,780	35,975	43,170	50,365	57,560	71,950
6	32,960	41,200	49,440	57,680	65,920	82,400
7	37,140	46,425	55,710	64,995	74,280	92,850
8	41,320	51,650	61,980	72,310	82,640	103,300
9	45,500	56,875	68,250	79,625	91,000	113,750
10	49,680	62,100	74,520	86,940	99,360	124,200
11	53,860	67,325	80,790	94,255	107,720	134,650
12	58,040	72,550	87,060	101,570	116,080	145,100
13	62,220	77,775	93,330	108,885	124,440	155,550
14	66,400	83,000	99,600	116,200	132,800	166,000

Sliding Fee Charges will be as follows:

Office Visits – Based on the qualifying percentage from the Annual Income Threshold Chart, or the nominal fee.

Labs - \$10 per lab CPT code.

Injections - \$10 per dose of any CHESI-provided injection and/or \$10 per patient-provided injection.

Procedures – Will follow the qualifying percentage from the Annual Income Threshold Chart. The minimum charge for procedures will be a 20% charge.

Personal Information

Name: _____

Mailing Address: _____

City/State/Zip: _____

Home Phone: _____ Alt Phone: _____

Number in Household: _____ List of household members receiving the sliding fee discount: _____

Income Information

Please choose your reported pay schedule – you will need to provide verification for at least one (1) month of income.

- Weekly - _____
- Bi-weekly - _____
- Monthly - _____
- Semi-Monthly - _____

Income is noted as any monies received by the patient or anyone in the household. Examples of income are as follows: Employment, Social Security, Child Support, Interest on bank accounts, Pensions, Retirement Funds, Veteran Funds, Medicaid Cash Assistance, WIC, LINK, and/or Rental Property.

<p><u>Office Use Only:</u></p> <p>Gross Annual Income: _____</p> <p>Approved: _____</p> <p>Denied: _____</p> <p>Reason for denial:</p> <p>_____</p> <p>_____</p> <p>Verified by: _____</p>
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Patient Signature: _____