Sliding Fee Scale Discount Application

COASTAL COMMUNITY HEALTH

NEW APPLICATION ☐ **RE-CERTIFICATION** ☐

APPLICANT INFORMATION

FULL NAME (First, MI, Last)	DATE OF BIRTH

CHECK HERE ONLY IF YOU **DO NOT** WANT TO APPLY FOR THE SLIDING FEE SCALE DISCOUNT

I have been given the opportunity to apply for the Coastal Community Health Center, Inc. (CCHS) discount services sliding fee schedule.

☐ ***I DO NOT wish to apply for the CCHS discount services sliding fee program at this time.***

SIGNATURE OF PATIENT OR GUARANTOR	DATE

GENERAL INFORMATION

The questions on this form will only be used to gather information about you and your family, so we can better meet your medical, dental, behavioral health, and/or vision needs (if you are insured, you may qualify for discounted copays or deductibles. If you are uninsured, you may qualify for discounted fees for services provided.) **This information will not be used to withhold or deny services.**

☐ Yes ☐ No Are you covered under Medicaid, Medicare, and/or any other insurance?

☐ Yes ☐ No Are you unemployed?

☐ Yes ☐ No Are you disabled?

HOUSEHOLD INFORMATION

Please include yourself, your spouse/partner, and all dependents receiving 50% or more of their support from the head of household.

Name	Date of Birth	Relationship to Applicant	Insurance	Insurance Type
		Applicant/Self	☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:_____
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:_____
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:_____
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:_____
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:_____
			☐ Yes ☐ No	☐ Medicaid ☐ Medicare ☐ Other:_____

DECLINATION OF DOCUMENTATION REQUIREMENTS

If you aren't able to comply with the documentation requirements, you are required to provide your cash income amount below, sign the applicant certification statement, and provide a letter from your employer on company letterhead that verifies the income amount you provide. **Failure to complete this information** will result in the denial of your application for a sliding scale discount.

MY CASH INCOME IS:	$	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Other:
CURRENT EMPLOYER:					

APPLICANT CERTIFICATION STATEMENT

I certify that I have no other way to document my income, and all of the above information is accurate. I understand this information is to be used to determine eligibility for the CCHS Sliding Fee Discount Program. I understand CCHS officials may verify information provided on this form.

SIGNATURE OF PATIENT	DATE

Sliding Fee Scale Discount Application

INCOME VERIFICATION

Please enter your **gross income** *(the dollar amount received before taxes are taken out)* in the table below. Household income includes all income generated by everyone in the household. Proof of income is required before the discount goes into effect.

Type of Income (Before Taxes or Deductions)	NAME OF PERSON RECEIVING INCOME #1	NAME OF PERSON RECEIVING INCOME #2	NAME OF PERSON RECEIVING INCOME #3	HOW OFTEN DO YOU RECEIVE THIS INCOME?
Work Wages	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Cash Wages	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Disability Income (non-military)	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Social Security	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Unemployment	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Worker's Comp	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Child Support	Not considered	Not considered	Not considered	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Alimony	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Tips	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Self-Employment	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Retirement	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Military Disability	Not considered	Not considered	Not considered	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:
Other Income	$	$	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other:

I understand that if I provide false information, I will be disqualified from the program, and all charges will be due in full immediately. I understand that I will be required to submit documentation of proof of income (1 month / 4 weeks of paystubs, prior year tax return, SSA letter, unemployment award letter, letter from employer, etc.). I understand that any insurance payments received by me or on my behalf must be applied to my account before I receive any discounts. By signing this form, I certify under penalty of perjury under the laws of the State of Georgia that the above information is true and correct, and I assume the responsibility of contact CCHS should any changes to my financial or insurance status occur.

APPLICANT SIGNATURE	**DATE**

FOR OFFICE USE ONLY (to be calculated once proof of income is received)

TOTAL NUMBER IN HOUSEHOLD:		SLIDING FEE SCALE: ☐ A ☐ B ☐ C ☐ D ☐ E	
GROSS INCOME AMOUNT #1:	$	DATE OF COMPLETED APPLICATION:	
GROSS INCOME AMOUNT #2:	$	BACKDATE DISCOUNT TO:	
GROSS INCOME AMOUNT #3:	$	INITIALS OF CCHS REPRESENTATIVE:	
TOTAL GROSS INCOME AMOUNT:	$	ADMINISTRATIVE APPROVAL IF BACKDATE IS MORE THAN 14 DAYS:	
TOTAL ANNUAL HOUSEHOLD INCOME	$		

Sliding Fee Discount Application

GIVE THIS PAGE TO PATIENT

STANDARD SERVICES SLIDING FEE SCHEDULE FOR QUALIFIED PATIENTS

	% of FPL					
	A	B	C	D	E	
	≤100% (Nominal Fee)	101%-133%	134%-167%	168%-200%	>201%-250%	>250%
Family Size	Annual Income					
1	≤$14,580	14,581 - 19,391	19,392 - 24,349	24,350 - 29,160	29,161 - 36,450	≥$36,451
2	≤$19,720	19,721 - 26,228	26,229 - 32,932	32,933 - 39,440	39,441 - 49,300	≥$49,301
3	≤$24,860	24,861 - 33,064	33,065 - 41,516	41,517 - 41,516	41,517 - 62,150	≥$62,151
4	≤$30,000	30,001 - 39,900	39,901 - 50,100	50,101 - 60,000	60,001 - 75,000	≥$75,001
5	≤$35,140	35,141 - 46,736	46,737 - 58,684	58,685 - 70,280	70,281 - 87,850	≥$87,851
6	≤$40,280	40,281 - 53,572	53,573 - 67,268	67,269 - 80,560	80,561 - 100,700	≥$100,701
7	≤$45,420	45,421 - 60,409	60,410 - 75,851	75,852 - 90,840	90,841 - 113,550	≥$113,551
8*	≤$50,560	50,561 - 67,245	67,246 - 84,435	84,436 - 101,120	101,121 - 126,400	≥$126,401
MEDICAL VISIT **	$ 25.00	$55	$75	$95	100% of Charges	100% of Charges
DENTAL VISIT ***	$ 50.00	$70	$100	$140	100% of Charges	100% of Charges
DENTAL PREVENTATIVE (cleaning)	$ 40.00	$60	$90	$110	100 % of Charges	100 % of Charges
LAB ONLY VISIT	$ 10.00	$20	$30	$40	100 % of Charges	100 % of Charges
VISION EXAM	$ 10.00	$20	$30	$ 40	100 % of Charges	100 % of Charges
IN-HOUSE PHARMACY DISPENSING FEES	$ 5.00	$10	$12	$ 14	NO DISCOUNT	NO DISCOUNT
CONTRACT PHARMACY DISPENSING FEES	$ 9.00	$11	$13	$ 15	NO DISCOUNT	NO DISCOUNT
FAMILY PLANNING VISIT (TITLE X)	$ -	$20	$45	$65	$85	100 % of Charges

* *For family units with more than 8 members, add $5,140 for each additional member. 2023 FPL figures are used*

** *Limited labs included in the visit fee.*

*** *Dental lab (crowns, bridges, dentures, night guards, etc.) are not subject to standard fee. Cosmetic elective procedures are priced separately. Additional charges apply.*

**** *340B Dispensing Fee only (uninsured). Cost of medication is charged separately.*

HOUSEHOLD INCOME *Combined gross income of all members for a household who are 18 years old and older. Alternatively, household income is the combined income of all members of a household who jointly apply for Sliding Fee Scale Discount. Household income includes any source of normally taxable income of the applying party and it includes wages, salary, social security benefits, disability income, and any other payments. Food stamps, child support, SNAP programs or any compensation not defined as taxable income are excluded from the calculation. Patient's assets (such as savings, IRA, 401(k)) are not considered income.*

HOUSEHOLD SIZE *Is the number of persons living in the household who cohabit, mutually contribute to household expenses and assert that they are a household unit. It is recognized that another person may reside at the common residence and not be considered as par of household unit (example: roommate).*

Effective 06/22/2023

To qualify for discount on services, patient must fill discount application and provide verifiable household size and household income.

HOUSEHOLD INCOME *Combined gross income of all members for a household who are 18 years old and older. Alternatively, household income is the combined income of all members of a household who jointly apply for Sliding Fee Scale Discount. Household income includes any source of normally taxable income of the applying party and it includes wages, salary, social security benefits, disability income, and any other payments. Food stamps, child support, SNAP programs or any compensation not defined as taxable income are excluded from the calculation. Patient's assets (such as savings, IRA, 401(k))*

HOUSEHOLD SIZE *Is the number of persons living in the household who cohabit, mutually contribute to household expenses and assert that they are a household unit. It is recognized that another person may reside at the common residence and not be considered as part of household unit (example: roommate).*

My Discount Is

Slide A _____

Slide B _____

Slide C _____

Slide D _____

Slide E _____

Your visit fee is due in full at the time of each visit

Your Sliding Scale Discount Expires on _____, 20___