**DATE**

 **NAME**

*IT IS NECESSARY FOR US TO ASK PERSONAL QUESTIONS IN ORDER TO GIVE YOU A DISCOUNT ON OUR FEES AND PHARMACEUTICALS. THIS INFORMATION WILL BE KEPT ON FILE IN OUR CENTER IN STRICT CONFIDENCE. YOU MUST VERIFY YOUR INCOME ANNUALLY IN ORDER TO REMAIN ELIGIBLE FOR OUR SLIDING FEE. YOUR ANNUAL GROSS INCOME AND HOUSEHOLD SIZE WILL BE USED TO CALUCULATE THE LEVEL OF YOUR PAYMENT.*

 **ADDRESS**

 **CITY STATE ZIP**

 **TELEPHONE NUMBER CELL NUMBER**

 **SOCIAL SECURITY NUMBER TOTAL HOUSEHOLD MEMBERS**

*HOUSEHOLD MEMBERS CONSIST OF ANY PERSON RESIDING IN THE HOME THAT IS A DEPENDENT OF THE APPLICANT*

 **DATE OF BIRTH**

**GIVENAMES, DATE OF BIRTH, AND SOCIAL SECURITY NUMBERS OF ALL MEMBERS LIVING IN THE HOUSEHOLD:**

|  |  |  |
| --- | --- | --- |
| **NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBE**R |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**DO YOU RECEIVE ANY INCOME FROM ANY OF THE FOLLOWING SOURCES? IF SO, HOW MUCH?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  **SOURCE** |  **YOU** |  **YOUR SPOUSE** |  **YOUR**  **CHILDREN**  |  **OTHER**  **PERSON**  |  **TOTAL** |
|  **WAGES/SALARIES/TIPS** |  |  |  |  |  |
| **SOCIAL SECURITY BENEFITS** |  |  |  |  |  |
| **NET SELF EMPLOYMENT** |  |  |  |  |  |
| **UNEMPLOYMENT BENEFITS** |  |  |  |  |  |
| **RETIREMENT AND PENSION** |  |  |  |  |  |
| **INVESTMENT/RENTAL INCOME** |  |  |  |  |  |

*YOU MUST PROVIDE DOCUMENTATION TO VERIFY THE ABOVE INCOME.*

*ACCEPTABE FORMS OF DOCUMENTATION INCLUDE:*

*\*\*\*\*MOST CURRENT 3 PAYSTUBS*

*\*\*\*\*LETTER FROM EMPLOYER*

*\*\*\*\*MOST CURRENT 2 BANK STATEMENTS*

*\*\*\*\*MOST CURRENT FEDERAL INCOME TAX RETURN*

*\*\*\*\*BENEFIT AWARD LETTERS*

**I understand payment is expected at each visit for all HAHC services.**

**I understand that at the time of service I will be required to pay the DETERMINED CHARGE on the Declaration of Income and Sliding Fee Application or the actual charge, whichever the lesser amount is.**

**I understand that I will be billed for any outstanding balances and it is my obligation to make payment in full or payment arrangements prior to my next scheduled visit.**

**I agree the information provided on this application is true and correct to the best of my knowledge. I agree that any misleading information or omissions may disqualify me from further consideration for the sliding fee program. I understand that I am requesting a discount for services provided by Hyndman Area Health Center. If I am granted a discount I understand I must comply with any and all requirements of the Sliding Fee Discount Program and meet my financial obligations at each visit. I agree to inform HAHC if any income information provided in this application changes before the annual renewal date.**

**SIGNATURE DATE**

**APPROVED DETERMINED CHARGE AMOUNT**

**MEDICAL NOMINAL FEE: DENTAL NOMINAL FEE:**

**$20.00 $20.00 or 15% of charges, whichever is less**

**$30.00 20% of charges**

**$40.00 25% of charges**

**$50.00 35% of charges**

**$60.00 50% of charges**

**FULL CHARGE FULL CHARCE**

**APPROVED BY DATE**

**HYNDMAN AREA HEALTH CENTER SLIDING FEE TABLE**

**Annual Income Thresholds by Sliding Fee Discount Pay Class and % of Poverty**

**MEDICAL/VISION SLIDING FEE TABLE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family Size** | **Nominal Charge $20.00** | **$30.00 Pay** | **$40.00 Pay** | **$50.00 Pay** | **$60.00 Pay** | **No Discount** |
| **Poverty Level** | **100% and Below** | **101%-125%** | **126%-150%** | **151%-175%** | **176%-200%** | **201% and Above** |
| **1** | **12,760** | **15,950** | **19,140** | **22,330** | **25,520** | **25,521** |
| **2** | **17,240** | **21,550** | **25,860** | **30,170** | **34,480** | **34,481** |
| **3** | **21,720** | **27,150** | **32,580** | **38,010** | **43,440** | **43,441** |
| **4** | **26,200** | **32,750** | **39,300** | **45,850** | **52,400** | **52,401** |
| **5** | **30,680** | **38,350** | **46,020** | **53,690** | **61,360** | **61,361** |
| **6** | **35,160** | **43,950** | **52,740** | **61,530** | **70,320** | **70,321** |
| **7** | **39,640** | **49,550** | **59,460** | **69,370** | **79,280** | **79,281** |
| **8** | **44,120** | **55,150** | **66,180** | **77,210** | **88,240** | **88,241** |

**DENTAL SLIDING FEE TABLE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family Size** | **Nominal Charge****$20.00** | **Pt Pays 20%** | **Pt Pays 25%** | **Pt Pays 35%** | **Pt Pays 50%** | **No Discount** |
| **Poverty Level** | **100% and Below** | **101%-125%**  | **126%-150%** | **151%-175%** | **176%-200%** | **201% and Above** |
| **1** | **12,760** | **15,950** | **19,140** | **22,330** | **25,520** | **25,521** |
| **2** | **17,240** | **21,550** | **25,860** | **30,170** | **34,480** | **34,481** |
| **3** | **21,720** | **27,150** | **32,580** | **38,010** | **43,440** | **43,441** |
| **4** | **26,200** | **32,750** | **39,300** | **45,850** | **52,400** | **52,401** |
| **5** | **30,680** | **38,350** | **46,020** | **53,690** | **61,360** | **61,361** |
| **6** | **35,160** | **43,950** | **52,740** | **61,530** | **70,320** | **70,321** |
| **7** | **39,640** | **49,550** | **59,460** | **69,370** | **79,280** | **79,281** |
| **8** | **44,120** | **55,150** | **66,180** | **77,210** | **88,240** | **88,241** |

**DENTAL SLIDING FEE TABLE- Elective Services**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family Size** | **Nominal Charge****$20.00** | **Pt Pays 50%** | **Pt Pays 60%** | **Pt Pays 70%** | **Pt Pays 80%** | **No Discount** |
| **Poverty Level** | **100% and Below** | **101%-125%**  | **126%-150%** | **151%-175%** | **176%-200%** | **201% and Above** |
| **1** | **12,760** | **15,950** | **19,140** | **22,330** | **25,520** | **25,521** |
| **2** | **17,240** | **21,550** | **25,860** | **30,170** | **34,480** | **34,481** |
| **3** | **21,720** | **27,150** | **32,580** | **38,010** | **43,440** | **43,441** |
| **4** | **26,200** | **32,750** | **39,300** | **45,850** | **52,400** | **52,401** |
| **5** | **30,680** | **38,350** | **46,020** | **53,690** | **61,360** | **61,361** |
| **6** | **35,160** | **43,950** | **52,740** | **61,530** | **70,320** | **70,321** |
| **7** | **39,640** | **49,550** | **59,460** | **69,370** | **79,280** | **79,281** |
| **8** | **44,120** | **55,150** | **66,180** | **77,210** | **88,240** | **88,241** |

\*\*\*In reference to all of the above tables the income ceiling for minimum fee pay class is equal to the federal poverty level. **Nominal Charge** is $20.00 for medical encounters & $20.00 for dental encounters. The 2020 federal poverty level guideline increases by $4,480 for each additional family member above 8.