Sliding Fee Scale Application

It is the policy of Coastal Community Health Center (CCHS) to provide essential services regardless of patient's ability to pay**. Discounts are available and offered to all active patients regardless of their insurance status.**

REQUIRED DOCUMENT	YES	NO
Proof of Identification – driver's license, employment ID, state issued id, or Government issued ID		
Proof of Income: - Prior year tax return, recent pay stub (month worth), pension, social security benefits, disability, veteran's benefits, unemployment compensation, retirement, alimony payments, reference letter to verify unemployment status - If income is paid in cash, provide letter from employer to include current date, date hired, employee's name and address, employer's name/address/phone number, wages per hour and how many hours of work per week, and frequency of pay period. The letter must be signed and dated by the employer		
FOR PATIENT WITH INSURANCE		
Insurance: Health insurance card, prescription coverage, supplement insurance card		
Medicaid: Medicaid card		
Medicare: Medicare card		

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee discount program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform the clinic if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of the clinic and hereby acknowledge that I read the foregoing disclosure and understand it.

I understand that if I am applying for financial assistance and do not have proof of income with me today, I will be responsible for 100% of my services at Coastal Community Health Services, I understand that I have thirty (30) days to provide all necessary information. Waiver of charges request must be approved by the office manager prior to my visit. I understand that my income will be subject to recertification at least annually.

STANDARD SERVICES SLIDING FEE SCHEDULE (CONVERSION TABLE)

	% of FPL					
	≤100%	101%-133%	134%-167%	168%-200%	>201%-250%	>250%
Family Size	Annual Income					
1	≤$12,490	12,491 - 16,612	16,613 - 20,858	20,859 - 24,980	24,980 - 31,225	≥$31,226
2	≤$16,910	16,911 - 22,490	22,491 - 28,240	28,241 - 33,820	33,821 - 42,275	≥$42,276
3	≤$21,330	21,331 - 28,369	28,370 - 35,621	35,622 - 42,660	41,561 - 53,325	≥$53,326
4	≤$25,750	25,751 - 34,248	34,249 - 43,003	43,004 - 51,500	51,501 - 64,375	≥$64,376
5	≤$30,170	30,171 - 40,126	40,127 - 50,384	50,385 - 60,342	60,343 - 75,425	≥$75,426
6	≤$34,590	34,591 - 46,005	46,006 - 57,765	57,766 - 69,180	69,181 - 86,475	≥$86,476
7	≤$39,010	39,011 - 51,883	51,884 - 65,147	65,148 - 78,020	78,021 - 97,525	≥$97,526
8*	≤$43,430	43,431 - 57,762	57,763 - 72,528	72,529 - 86,860	86,861 - 108,575	≥$108,575
MEDICAL VISIT **	$ 20.00	$50	$70	$90	100% of Charges	100% of Charges
DENTAL VISIT ***	$ 45.00	$60	$85	$140	100% of Charges	100% of Charges
DENTAL PREVENTATIVE (cleaning)	$ 35.00	$55	$80	$100	100 % of Charges	100 % of Charges
LAB ONLY VISIT	$ 10.00	$20	$30	$40	100 % of Charges	100 % of Charges
FAMILY PLANNING VISIT (TITLE X)	$ -	$20	$45	$65	$85	100 % of Charges

** For family units with more than 8 members, add $4,320 for each additional member. 2018 FPL figures are used*

*** Lab visits are billed separately*

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

Date:_____ Name (Print):_____

Applicant Signature _____ CCHS Signature _____

CCHS Sliding Fee Discount Application Form

Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

Household Income

Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Assigned discount