HAHC, INC.
HYNDMAN AREA HEALTH CENTER

Sliding Fee Discount Eligibility Form

MEDICAL ☐
DENTAL ☐

DATE

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 CALCULATE THE LEVEL OF YOUR PAYMENT.

NAME

ADDRESS

CITY **STATE** **ZIP**

TELEPHONE NUMBER **CELL NUMBER**

SOCIAL SECURITY NUMBER

TOTAL HOUSEHOLD MEMBERS

DATE OF BIRTH

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

GIVE NAMES, DATE OF BIRTH, AND SOCIAL SECURITY NUMBERS OF ALL MEMBERS LIVING IN THE HOUSEHOLD:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

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					

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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 HAHC if any income information provided in this application changes before the annual renewal date.

SIGNATURE **DATE**

APPROVED DETERMINED CHARGE AMOUNT

MEDICAL NOMINAL FEE ($20.00):	**DENTAL NOMINAL FEE ($20.00):**
$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	12,490	15,613	18,735	21,858	24,980	24,981
2	16,910	21.138	25,365	29,593	33,820	33,821
3	21,330	26,663	31,995	37,328	42,660	42,661
4	25,750	32,188	38,625	45,063	51,500	51,501
5	30,170	37,713	45,255	52,798	60,340	60,341
6	34,590	43,238	51,885	60,533	69,180	69,181
7	39,010	48,763	58,515	68,268	78,020	78,021
8	43,430	54,288	65,145	76,003	86,860	86,861

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	12,490	15,613	18,735	21,858	24,980	24,981
2	16,910	21.138	25,365	29,593	33,820	33,821
3	21,330	26,663	31,995	37,328	42,660	42,661
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