Hyndman Area Health Center

On Track For Better Health

MEDICAL_____

Sliding Fee Discount Eligibility Form

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 CALUCULATE 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					
INVESTMENT/RENTAL INCOME					

MEDICAL_____

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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

MEDICAL_____

Sliding Fee Discount Eligibility Form

DENTAL_____

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.