**Information about Sliding Scale**

**What is sliding scale?**

*A sliding scale is the method we use to offer discounts on healthcare from Delhi Community Health Center based on a patient’s household size and income.*

**What happens if I don’t apply?**

*You will be asked to pay the full charges for the services provided if you choose not to apply.*

**What is income?**

*Earnings, unemployment compensation, workers’ compensation, Social Security, SSI, interest, dividend, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, food stamps, other miscellaneous sources.*

**How can I prove my income?**

* *Prior year W2*
* *Two most recent pay stubs*
* *Verifiable letter from employer*
* *Form 4506-T if W2 not filed*
* *Last 3 months of business income and expenses if self-employed*
* *If no income and unable to provide verification, letter from outreach organization (church or shelter)*
* *Self-declare (initial visit only); must present proof at next visit or will be responsible for entire charge.*

**What if I don’t bring proof of income?**

*You will receive a bill for the full cost of your visit/services from Delhi Community Health Center after a prescribed amount of time has been given for you to return this information.*

**What if this information changes?**

*If your income or household size changes, please inform the receptionist. You will be asked to fill out a new application and show proof of the new income.*

**What services does Sliding Scale cover?**

*Sliding scale offers discounts on the clinic visits and all services provided at Delhi Hospital.*

**What services are NOT COVERED under Sliding Scale?**

*Sliding Scale does not cover the cost of pathology and the reading of the radiology test done by the radiologist. You will still receive a bill from the pathologist or radiologist if those services were done.*

**What if my fees are still too expensive?**

*One of our clinic staff will direct you to the appropriate Certified Applications Counselors at our facility to see if you qualify for reduced cost healthcare with Medicaid or the Insurance Marketplace.*

**Delhi Community Health Center**

**Sliding Scale Discount Application**

Sliding Scale is a discount program we offer to our patients. The discount you qualify for is based on your household size and income. Please fill out this application and **provide proof of monthly gross income for ALL members of the household** to the receptionist. If you have questions, see the information on the next page or ask the receptionist for help.

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_ Jr. Sr. III

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip

Home (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_ Work (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_

**Insurance Information**

Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy or Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Policy Holder’s SSN# \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Policy Holder’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip

**Household Members and Income**

Are you receiving any one of the following benefits? (We must have copies of any that are marked YES. Without proof of income, you will not receive a discounted price)

Are you currently employed?

**YES / NO**

What is your gross annual income?

\_$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of employment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Phone #

(\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Y** | **N** | **If so, how much?** |
| Medical Assistance |  |  |  |
| State Public Assistance |  |  |  |
| SSI/SSDI |  |  |  |
| Social Security |  |  |  |
| Veterans Retirement/Disability |  |  |  |
| Workers Compensation |  |  |  |
| Unemployment |  |  |  |
| Other (Alimony, Child Support) |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Annual Income in your household** | | |
| $10,000 - $20,000 | $36,000 - $40,000 | $51,000 + |
| $21,000 - $35,000 | $41,000 - $50,000 |  |

*How many people live in your household? \_\_\_\_\_\_\_\_\_\_*

List their names, birth dates, income, & SSN if available

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date of Birth** | **SSN#** | **Relationship** | **Annual Income** |
|  | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_\_-\_\_\_\_-\_\_\_\_ |  |  |
|  | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_\_-\_\_\_\_-\_\_\_\_ |  |  |
|  | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_\_-\_\_\_\_-\_\_\_\_ |  |  |
|  | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_\_-\_\_\_\_-\_\_\_\_ |  |  |
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|  | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_\_-\_\_\_\_-\_\_\_\_ |  |  |
|  | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_\_-\_\_\_\_-\_\_\_\_ |  |  |
|  | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_\_-\_\_\_\_-\_\_\_\_ |  |  |
| **Total monthly gross household income (earned and unearned): $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |

Required Documentation Checklist. Have you included:

* *Prior year W2*
* *Two most recent pay stubs*
* *Verifiable letter from employer*
* *Form 4506-T if W2 not filed*
* *Last 3 months of business income and expenses if self-employed*
* *If no income and unable to provide verification, letter from outreach organization (church or shelter)*
* *Self-declare (for initial visit only); must present proof at next visit or will be responsible for entire charge.*

TO RETAIN SLIDING FEE SCALE PRIVILEGES, PROOF OF INCOME MUST BE SUPPLIED WITHIN 10 DAYS OF THIS APPLICATION.

“This information is true and correct to the best of my knowledge. I understand that if my household’s monthly gross income changes, I must fill out a new application and show proof of the new income amount. I give Delhi Community Health Center permission to verify information about my financial status. Failure to meet those conditions may disqualify me from the future Sliding Scale fee discounts. I authorize the release of any medical or other information necessary to process claims on my behalf or as necessary to facilitate my care or the care or the care of my minor child. I understand that by applying for and receiving a discount does not mean that my Medical Services are free and that I am responsible for remaining balances.”

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

Patient declined to complete\_\_\_\_\_

Verified by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_\_\_\_ Category: \_\_A \_\_B \_\_C \_\_D \_\_E

PATIENT OR GUARDIAN SIGNATURE