Sliding Fee Scale Application Form

Ohio North East Health Systems, Inc. offers for its patients, a SLIDING FEE SCALE for discounted charges based on family size and income. Funding for the Sliding Payment Scale is made available through a grant from the Department of Health and Human Services. Re-verification of income is needed semi-annually, or earlier if your income changes. **Patients must supply proof of income within 72 hours of visit, or you will be responsible for the full charge.** Documentation of proof of income is subject to audit review of accuracy. The discount will apply to all services received at this clinic, but not those services which are purchased from outside facilities, including laboratory testing, drugs, x-ray interpretations by a consulting radiologist, and/or other such services. Discounts will only apply to current services. Falsified documentation is subject to penalty. NOTE: Patients eligible for Medicaid or Medicare are to apply directly to that program.

Section I

Patient's Name: ____________________________ DOB: _______________SS#: ______--____--______

Household Members – All persons who live together in the same housing unit (house, apartment, etc). Circle one: 1 2 3 4 5 6 7 8 Other: ______

Household Member Name	Social Security Number	Date of Birth

Total Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits.				
Alimony, child support, military family allotments.				
Income from business, self employment, and dependents.				
Unemployment, worker compensation, strike benefits, etc.				
Rent, interest, dividend, royalty, and other income.				
Total Monthly Household Income				

I certify that the information shown above is correct and understand verification is required for approval. I agree to notify the health center if there are any changes in my household income, size or if I receive health insurance benefits including Medicare or Medicaid. Failure to report any changes may result in dismissal from the Sliding Fee Scale and my account will be adjusted as such. I agree to pay any outstanding balances and understand that payment plans are available to me.

_______________________________________ ____

Name (Print) Signature/Date

Staff- please complete back of application form →

Section II # [FOR STAFF USE ONLY]

Verification Checklist (Attach Copies)

The patient has provided the following proofs of income sections (please check all that apply):

Section A *(Required)*

- ☐ Complete Income Tax Statement IE: 1042, 1040 from prior year.
- ☐ If client does not file tax returns Form 4506 T (Request for Transcript of Tax Return) must be completed. Form 4506 T should also be completed for the current year.
- ☐ Identification with address: Driver's license, employment or other picture ID.
- ☐ Client has started new employment and has provided 30 days worth of current paystubs.

Section B *(And furnished any of the following)*

- ☐ Workers Compensation Income - copy of the benefit check, stub, or award letter.
- ☐ Current paystubs.
- ☐ Unemployment Compensation - award letter.
- ☐ SSDI or SSI Payments - award letter.
- ☐ Retirement Income – copy of payment stub or EOB.
- ☐ Social Security (OASDI) payment - award letter.
- ☐ Child Support or Alimony Income - court documents.
- ☐ CFSA Stipend or Federal Foster Care Payment - award letter or check stub.
- ☐ Military or Veteran Income – copy of payment stub.

Request for consideration of extenuating circumstances: ____

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Sliding Fee Scale Approved: Yes ☐ No ☐ Effective Date:__________

☐ Nominal Fee= A ☐ 75%= D

☐ 25%= B ☐ 100%=E

☐ 50%= C

Approved By:________________________________ Expiration Date:____________________