Sliding Fee Scale Application Form

Ohio North East Health Systems, Inc. offers a SLIDING FEE SCALE to its patients for discounted charges based on family household size and income. Funding for the Sliding Fee Scale is made available through a grant from the Department of Health and Human Services. The discount only applies to services received at this clinic and not those which are purchased from outside facilities including laboratory testing, drugs, x-ray interpretations by a consulting radiologist, and/or other such services.

For eligibility consideration, the application form and proof of income must be submitted within two weeks after service date and annually thereafter or earlier in circumstances when income changes. Proof of income documentation will be reviewed for authenticity and accuracy. Falsifying documents may be subject to legal penalty**. If this form is not filled out completely and returned with proof of income it will not be processed.**

Section I

Date:_____

Patient's Name:_____DOB:_____SS#:_____
Household Size – All family members 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

Annual Household Income

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

☐ **Refused Sliding Fee**

_____ _____

Name (Print) Signature/Date

Section II

[FOR STAFF USE ONLY]

Verification Checklist (Attach Copies)

The patient has provided the following POI (please check all that apply):

- ☐ Income Tax Statement - 1042, 1040 from prior year.
- ☐ Form 4506 T (Request for Transcript of Tax Return) - patients who do not file taxes.
- ☐ Current Paystubs - at least two recent paystubs
- ☐ Letter of Employment - patients with new employment and do not have at least two paystubs.
- ☐ Self-Employment - three most recent months of business income and expenses.
- ☐ Workers Compensation Income - benefit check, stub, or award letter.
- ☐ Unemployment Compensation - award letter.
- ☐ SSD or SSI Payments - award letter.
- ☐ Retirement Income – explanation of benefits.
- ☐ Social Security (OASDI) payment - award letter.
- ☐ Child Support or Alimony Income - court documents.
- ☐ CFSA Stipend or Federal Foster Care Payment - award letter.
- ☐ Military or Veteran Income – award letter.

Request for consideration of extenuating circumstances: _____

_____

_____

Sliding Fee Scale Yes ☐ No ☐

Effective Date:_____ Expiration Date:_____

☐ Nominal Fee= A

☐ **Pay** 25%= B

☐ **Pay** 50%= C

☐ **Pay** 75%= D

☐ **Pay** 100%=E

Approved By:_____ Date:_____