East Liberty
Family Health Care Center
A CHRISTIAN MINISTRY OF
WHOLE PERSON HEALTH CARE

SLIDING FEE DISCOUNT APPLICATION

We are committed to providing quality health services to all of our patients regardless of their ability to pay. This application will determine if a sliding fee discount is available for you based solely on your household income and family size.

Household Income – any taxable or non-taxable income that would be reported on a tax return. *Examples:* Wages, social security benefits, child support, public assistance, alimony, unemployment benefits.

Noncash benefits (such as food stamps and housing subsidies) ***do not*** *count.*
Family Size – the householder and spouse plus anyone who is typically included as a dependent on a tax return

Household Income: Member's Name/D.O.B./Amount - Frequency (annually, monthly, bi-weekly, weekly) - **Source** (wages, alimony, etc.

Household / Member Name / DOB	**Income/Amount**	**Frequency of Payment** (Annually, Monthly, Bi-Weekly, or Weekly)	**Source of Income** (wages, alimony, etc.)
Self			
Spouse			
	TOTAL		

_____I understand that basic dental and medical including in-house labs will be covered under the sliding fee discount program.
_____ I understand that I am responsible for any outside lab or major dental work charges.
_____I understand that failure on my part to submit proof of income will result in suspension of my sliding fee discount.

I certify that the family size and income information shown above is correct. I understand that I am responsible for submitting proof of income before any discounts can be approved and continued.

_____ _____ _____
Print Name Signature Date

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I am providing this affidavit to verify my income, as I have no other income documentation available to me. *(Yo estoy haciendo este documento oficial para verificar, como no tengo otra documentación disponible.)*

I declare that our income is from *(Yo declare que nuestros ingresos son de*):

Family member's name who receives income (nombre del miembro de familia quien recibe ingreso	Source of Income (Fuente de ingreso)	Amount received (Cantidad recibido)	How often received (Cuanta frequencia recibido)	Total for year *(Total del año)*

I certify that our family will recieve a total yearly income of (*Yo certifico que nuestra familia recibirá un ingreso total del año de*) $_____.

I understand that this information is subject to verification by the state of Pennsylvania. I certify that the information presented in this letter is true and correct to the best of my knowledge and belief. *(Yo entiendo que esta información esta sujeto al verificación por el estado de Pensilvania. Yo certifico que la información presentada en esta carta esta verdadera y correcta a lo mejor de mi conocimiento y creencia.)*

Signed (Firmado),

Name (*Nombre completo*) _____

Signature (*Firma*) _____

Date (*Fecha*) _____

PUBLIC NOTICE SIGNAGE

Sample Discount Fee Policy Signs

Notice to Patients

This practice serves all patients regardless of ability to pay

Discounts for essential services are offered depending upon family size and income.

You may apply for a discount at the front desk

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AVISO PARA PACIENTES

Los centros de salud ofrecen servicios de atención médica primaria y preventiva, sin considerar la capacidad de los pacientes para pagar.

Los cargos generados por servicios de salud son calculados de acuerdo al nivel de ingreso del paciente.

Pacientes pueden aplicar para servicios médicos con la recepcionista en la clínica.

NOTICE

THIS PRACTICE HAS ADOPTED THE FOLLOWING POLICIES FOR CHARGES FOR HEALTH CARE SERVICES

We will charge persons receiving health services at the usual and customary rate prevailing in this area. Health services will be provided at no charge, or at a reduced charge, to persons unable to pay for services. In addition, persons will be charged for services to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.

We will not discriminate against any person receiving health services because of his/her inability to pay for services, or because payment for the health services will be made under Part A or B of Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act.

We will accept assignment under the Social Security Act for all services for which payment may be made under Part B of Title XVIII ("Medicare") of the Act.

We have an agreement with the State agency which administers the State plan for medical assistance under Title XIX ("Medicaid") of the Social Security Act to provide services to persons entitled to medical assistance under the plan.