# Sliding Discount Fee Schedule Information & Application

**What is the Sliding Discount Scale Fee Schedule?**

The Sliding Discount Scale Fee Schedule (SDS) is part of a federal program (Federally Qualified Health Centers - FQHC) that allows Bay Clinic, LLP to discount normal charges for medical visits for our qualifying patients based on household size and household income. In order to qualify for the program, patients must provide proof of income below 200% of the current federal poverty level.

Eligibility for the Sliding Fee Discount Program is only based on your family size and income.

**Family size** is defined as a group of two or more persons related by birth, marriage, adoption, or legal partnerships (i.e., domestic partnerships) who live together; all such related persons are considered as members of one family. This includes students, regardless their residence, who are supported by their parents or others related by birth, marriage, or adoption, or legal partnerships (i.e., domestic partnerships). Self declaration is used for family size.

**Income** is defined as total annual cash receipts, before taxes from all sources, including wages and salaries before any deductions, net receipts from self-employment, regular payments from social security, unemployment compensation, alimony, child support, military family allotments, pensions, and regular insurance or annuity payments, dividends, interest, net rental income. Documentation to support income are pay stubs, recent federal tax return, copy of W2 form, gross income verification completed by the employer, and/or copies of bank statements. Other documentation may be used if needed and approved by Clinical Site Manager. If you cannot provide income information, you may self- declare your income by filling out the self-declaration form.

**At the time of service, a nominal payment is due for all patients whose application is pending, dependent on the type of service and income.**

****Any Services that are deemed Not Medically Necessary (including cosmetic services) will NOT be discounted.****

You and eligible dependents in your household may qualify for discounted services provided by Bay Clinic, even if you have insurance or Medicare. To see if you qualify for discounted services, please complete the information on the following page.

If you need help, our staff can assist you to complete the application.

You can make an appointment and receive services before your application is approved.

# 2024 Sliding Fee Application

**Name:**_____ **DOB:**_____

**Home Phone:**_____ **Mobile Phone:**_____

**Mailing Address:**_____

**Number of persons living in your family (as defined above):** _____

**Total monthly household income before taxes:** _____

| **Please list everyone in your household/family that you are applying for: (Including yourself)** | | | |
|---|---|---|---|
| **Name** | DOB | Monthly Gross Income | Income Source |
| | | | |
| | | | |
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**I am providing the following as proof of income. Please check all that apply.**

| **PROOF OF INCOME** | | **PROOF OF INCOME** | |
|---|---|---|---|
| Prior Year's Taxes | | Support from Family Member | |
| Wages and Salary (or Paystubs) | | Pension Funds | |
| Unemployment | | VA Benefits | |
| Self-employment | | Alimony/Child Support | |
| Workers' Compensation | | Scholarships/Grants | |
| Public Assistance (EBT/TANF) | | Other (specify) | |
| Disability or Social Security | | | |
| **Self-Declaration (I am unable to provide proof of income)** ** | | | |

**If you choose the self-declaration option as proof of income, you must complete the Alternative Income Verification Form. Please ask a staff member for one of these forms to complete.

Do you have health insurance? ◯ YES ◯ NO If yes, please bring your cards at every visit.

Plan Name:_____ Member ID:_____ Annual Deductible_____
(If Known)

Plan Name:_____ Member ID:_____ Annual Deductible_____
(If Known)

# Authorization & Release Form

I certify the family size and household income information is accurate and correct, to the best of my knowledge. I agree that providing incorrect or falsified information or by omitting relevant information may disqualify me from the Sliding Fee Discount Program.

I understand that I can supply proof of income or self-declare my income.

I understand that some of the information I provide is protected by Federal and/or State law, and this release allows Bay Clinic, LLP, and its representative, to verify only the financial information needed to determine eligibility for the Sliding Fee Discount Program.

I hereby release and hold harmless all individuals who provide information to verify my income. I agree to update my household income and family size every 12 months or whenever it changes.

In signing this form, I agree to pay my portion of the fees for each visit and that the fee may be adjusted based on my sliding fee application. I will contact Bay Clinic, LLP if I need to set up a payment plan.

I understand that Bay Clinic, LLP works with other healthcare partners who may reduce their fees for services and that their sliding fee scale may differ from Bay Clinic, LLP fees.

| _____ | _____ | _____ |
|---|---|---|
| **Patient Name (please print)** | **Signature** | **Date** |

OFFICE USE ONLY

Sliding Scale Rate Approved_____ Approved By_____ Effective Date_____ Expiration Date_____

Patient Account Number_____

Notes: