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.

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

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.

________________________________ ________________________________ ______________

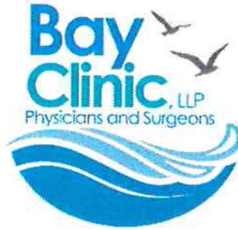
Patient Name (please print) **Signature** **Date**

OFFICE USE ONLY

Sliding Scale Rate Approved_____________ Approved By____________ Effective Date__________ Expiration Date_________

Patient Account Number_________________

Notes:



1750 Thompson Rd Coos Bay, OR 97420
Phone: 541-269-0333 Fax: 541-269-7389

Sliding Fee Discount Program
Alternative Income Verification Form

Only complete this form if you have checked the Self-Declaration option on the Sliding Fee Discount Program Application.

Name: ____________________ **Home Phone:** ____________ **Mobile Phone:** ____________
DOB: ____________________

Mailing Address: ____
____

Number of persons living in your family reported on your Sliding Fee Discount Program Application: _____
Total monthly household income before taxes: ____________

I am not able to provide proof of my income. Please give a brief statement of why you are not able to provide proof and how you currently pay for your living expenses.

____
____
____
____
____

I hereby submit to Bay Clinic LLP my unverified income information to be used to determine my eligibility for the Sliding Fee Discount Program. I agree that providing incorrect or falsified information or by omitting relevant information, I may be disqualified from the Sliding Fee Discount Program.

______________________________ ______________________________ __________
Patient Name (please print) **Signature** **Date**

OFFICE USE ONLY

Date Received: ________ **Received By:** __________ **Patient Account Number:** ________________

Notes: