Family Health Care of Northwest Ohio, Inc.
1052 S. Washington Street
Van Wert, OH 45891
Phone: 419-238-6747 Fax: 419-238-3721

Sliding Fee Scale Patient Information

Patients with household income up to and including 200% of the poverty level may apply for the Sliding Fee Discount.

Procedure:

1. A patient may apply for a Sliding Fee Discount by filling out the Sliding Fee Scale Application Form
2. The patient must also present proof of gross household income:
    a. Salary & Wages – 2 to 3 check stubs/ Tax return (1040)
    b. Social Security/Disability – Statement from agencies
    c. Unemployment – Notice of unemployment compensation eligibility or determination of unemployment compensation benefits
    d. Workers Compensation – Statement from agency
    e. Child Support – Statement from Child Support Enforcement Agency
    f. Pension – Statement
    g. Any Other Income – written proof
3. The combination of household income and number of household members determines the adjustment percentage
4. The patient must fill out the Sliding Fee Scale Application Form prior to first visit or at the first visit. Patient has 30 days from the date of service to bring in proof of income. After the 30 days a bill will be sent out to the patient for the full charge amount. If no proof of income is received within 60 days from date of service, no sliding fee discount may be given.
5. A new Sliding Fee Scale Application Form will be filled out annually or if there is a change in household income
6. The Sliding Fee Scale will be adjusted annually to reflect changes in the Federal Poverty Levels
7. A nominal payment of $20.00 will be requested prior to each visit. A hardship appeal form may be filled out if a patient believes there is valid reason that they cannot pay.
8. If a patient has insurance with a high deductible, the insurance company will be billed
    a. Patient will then have option to follow Procedures #1 and #2 above and be placed on sliding fee scale for remainder of the bill
9. It is the responsibility of the patient to pay the appropriate insurance co-pay at the time of the visit. The slide will be applied after the insurance co-pay. If the account becomes delinquent and is turned over to Small Claims Court, a slide cannot be given on the outstanding amount.
10. Client agrees to pay to Family Health Care all insurance proceeds received by the client for services provided by Family Health Care.
11. Services not covered under the Sliding Fee Scale: Vaccines, non-routine medical supplies, any outside services.
12. Failure to disclose accurate financial information will be cause for discharge from Family Health Care.

Family Health Care

Sliding Fee Discount Application

It is the policy of Family Health Care to provide health care services to patients in need. Discounts are offered to members of households with combined income of less than double the Federal Poverty level. If you prefer not to provide this information, please sign the following waiver and return this form to the front desk. Thank you.

Waiver:

I choose not to provide the following information at this time. I am waiving my right to any discount to which I may otherwise be entitled.

Patient Name (Please print)	Signature of Patient or Guarantor	Date

In order to determine the percentage for which you qualify, please complete the following information and return to the front desk.

 # OF PEOPLE SUPPORTED BY THE HOUSEHOLD INCOME BELOW (Please List):

First Name	MI	Last Name	Birth Date	Social Security #	Relationship	Patient Y/N

Note: Include income from all people in the household and from all sources, including wages, tips, Social Security, disability, pensions, annuities, veteran payments, military, self employment, alimony, child support, unemployment, public aid, and any other income from any other source. Supporting documentation is required before the Sliding Fee Discount can be approved, and approved discounts will be valid for up to one year. **Acceptable forms include: copies of two recent checks/stubs, W-2, recent tax return, public assistance or Social Security check/stub or letter of award, Medical Assistance or Dept. of Social Services Certification Letter, proof of Governmental Assistance, or proof of zero or limited income.**

Total Household Income (Please Complete Only one Column):

Member	Annual	Monthly	Bi-Weekly	Weekly
Self				
Spouse				
Children				
Relatives/others				
Total				

Certification:

I certify that the household size and income information shown above is correct. **I understand that the documentation supporting my household financial position is required before my discount can be approved.** I understand that I must update this information if my situation changes, and that a new Discount Application must be completed at least every twelve (12) months. I have received information explaining the program and I understand and agree to abide by the terms. **I understand that if I am a self –pay patient, I must pay a minimum of $20 prior to receiving any health care services.** I understand that this document will be notarized and by signing below I acknowledge that the information I have provided is honest and up to date information. **I understand that the Family Health Care has the right to discharge me as a patient if I have falsely provided information in regards to my household and its income.**

Patient Name (Please Print)	Signature of Patient or Guardian	Date

Office use only

Documentation	%	Date
Received/Reviewed		