De Baca Family Practice Clinic

Sliding Fee Discount Application

It is the policy of De Baca Family Practice Clinic (DBFPC) to provide access to essential primary care services to all patients regardless of the patient's ability to pay. The Sliding Fee Discount Program is designed to provide discounted care to patients based on income and family size and no other factors. Please complete the following information and return to DBFPC's Enrollment & Outreach Counselor or the Front Desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside.

Sliding Fee patients can receive a discount on outside diagnostic services, including pathology, laboratory and radiology testing. DBFPC will provide assistance for pathology, laboratory and x-ray bills. Patients must bring their bills to the clinic within sixty-(60) days of the date of service. DBFPC also participates in the 340B drug program to provide discounted prescription drugs for Sliding Fee Patients.

This form must be completed every 12 months and/or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET ADDRESS	CITY	STATE	ZIP	PHONE
MAILING ADDRESS	CITY	STATE	ZIP	ALTERNATE PHONE

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE:

I certify under the penalty of perjury that the statement in regards to family size and income is true and correct to the best of my knowledge. I also understand that this is not a guarantee of payments for services not covered under Sliding Fee and I agree to be financially responsible for non-covered services. I also understand that this eligibility is for discounted coverage only for Sliding Fee and is effective through March 31st of each year regardless of date application was filed. I must bring in verification of income on an annual basis in order to continue coverage. I also understand that I may need to bring in additional documentation and information to be eligible for specific benefits.

Name (Print) _____

Signature _____ Date _____

Office Use Only

Patient Name: _____

Eligibility Clerk: _____ Date Processed: _____

Approved Discount: _____

Sliding Fee Manager: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, W-2, one month most recent pay stubs, or other		
Insurance: Insurance/Medicaid Cards		

De Baca Family Practice Clinic

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SLIDING FEE SCALE INFORMATION SHEET

PLEASE READ:

- All Sliding Fee patients are responsible for a nominal fee, regardless of the amount charged for the visit or the qualifying discount level of the patient.
- All nominal fees are based per visit.
- Please see attached SFS Fee Schedule.

PRESCRIPTION DRUG PLAN (340 B DRUG PLAN)

The 340B drug program provides discounted prescription drugs for Sliding Fee Scale Patients.

- Patient's prescriptions will be sent by the Provider electronically (when applicable) to Addison Drug Store. Medications requiring paper prescriptions will be given to the patient who must present it to Addison Drug to be filled.
- Prescription must be related to a service provided on that day.
- Prescriptions are discounted but the patient must pay their portion of the cost on that day.

BENEFIT SCHEDULE B

Sliding Fee INCOME LEVEL	**Drug Cost** *(the actual amount the Clinic pays for the drug)*
Plan A	$5 dispensing fee + the drug cost
Plan B	$5 dispensing fee + drug cost + 5%
Plan C	$5 dispensing fee + drug cost + 10%
Plan D	$5 dispensing fee + drug cost + 15%

Example: *A Plan B Sliding Fee patient has a prescription for a drug that the Clinic has paid $3.00 to purchase. The patient pays the $5 dispensing fee plus $3 for the cost of the drug plus an additional 5% (Plan B Discount) of the drug cost ($3 x 5%=$.15) for a total of $8.15.*

OUT-SOURCED LABORATORY & X-RAY FEES

- Pathology, Laboratory and x-ray tests that must be sent elsewhere for processing will generate a separate bill. Sliding fee patients can receive assistance on these services. Patients .

- Patients must bring their bills to the clinic within sixty-(60) days of the date of service.

APPLICATION PROCESS

Sliding Fee Clerks are available Monday through Friday to assist patients with the application process. In addition to completing the application, the following documentation is required:

1. Copy of your ID: Examples include a driver's license, employment ID, utility bill, or birth certificate.

   Proof of Income: Examples include prior year income tax return, W-2's, pay stubs from last 30 days of work, letter from employer, or Form 4506-T.

2. Proof of household size and dependents: Examples include birth certificate, immunization records, baptismal records or school ID.

Patients will qualify for the program based on household size (HHS) income guidelines. Patient's income cannot exceed the maximum income listed below, according to their family size. Gross income will be verified to determine eligibility for discount benefits.

Federal Poverty Guidelines

Family Size	Maximum Income
1	$25,520
2	$34,480
3	$43,441
4	$52,401
5	$61,361
6	$70,321
7	$79,281
8	$88,241

All qualifying applications will expire on March 31st of the calendar year. You will receive a notice by mail approximately 45 days before your eligibility expires. At that time, you must renew your application to avoid a lapse in coverage.

By applying for participation in the Sliding Fee Scale program, you consent to the disclosure of non-public personal information about you and members of your household (including any minor children) to Participating Providers and Third-Party Payers.

It is your responsibility to notify us if your income or address changes.

**You and your family may also be eligible to receive Medicaid benefits, assistance is available through the Clinic's Outreach and Enrollment Program Clerk. The Clerk is also available to assist patients wishing to enroll in the Health Insurance Exchange.

PATIENT ACKNOWLEDGEMENT OF FEES

I understand that each visit requires a nominal fee.

_____Initial

I understand that some services and procedures such as major dental work and lab and x-ray services have a different discount level.

_____Initial

I understand that I must have all the required documentation turned in to my Sliding Fee counselor within 14 days of my application before the discount will be applied to my bill. If I fail to provide this documentation, I will be responsible for the full amount charged for services.

_____Initial

_____

Patient Signature

_____

Sliding Fee Eligibility Clerk

_____

Date