



SLIDING FEE APPLICATION

The Sliding Fee Scale is a method for providing reduced fees, based on a household's size and income. In order to be eligible for this program, the following application must be completed, signed & dated with **proof of income (see listing for acceptable forms of income)** and approved.

Head of household: Last _____ First _____ Phone _____

Mailing address: _____ City _____ State _____ Zip _____

Have you or any of your household members applied for Medicaid (Title XIX)? Yes No

SOURCES OF INCOME: All members living in the household. "Household" is considered tax filer + spouse + tax dependents. Please refer to chart for more information. **If your living situation is temporary, please advise the financial screener.**

Source	Amount (\$)	Weekly	Bi-Weekly	Monthly	Annually	Annual Income
Salaries and Wages (self)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Salaries and Wages (spouse)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Salaries and Wages (other)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unemployment Compensation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Security (Self/Spouse)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Security (Children)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SSDI (Social Security Disability Income)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alimony		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Military / Veterans Benefits		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unemployment Benefits		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rental/Investment Income		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Capital Gains Income		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Family Members		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

HOUSEHOLD SIZE: List all household members by NAME, DATE OF BIRTH, AND SS#, include yourself:

NAME	DATE of BIRTH	RELATIONSHIP	SOCIAL SECURITY #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE READ THE FOLLOWING CAREFULLY

I declare that my household's financial status is as listed above. I understand the following:

- Gracepoint is utilizing federal tax dollars to assist me in receiving health care
- Giving false information regarding my household income is considered fraud against the U.S. government
- Any change in my finances or the number of people in my household must be reported to Gracepoint and a new application must be completed

Applicant's Signature _____ Date _____

Check and sign only if applicable: I have been informed of and understand the possible financial benefits of participating in the sliding fee scale process; however at this time I do not wish to participate.

Patient Signature _____ Date _____

Patient Name: _____

ID #: _____

You are required to provide proof of listed income in order to complete your application. The following are acceptable forms of income:

- Current Federal Income Tax (1040, 1040A or 1040 EZ Form)
- Paystubs for recent month
- Current bank statement showing direct deposit or most recent check stubs totaling one month payment (SS, SSI, SSD, Retirement accounts and/or payments, Alimony, etc.)
- Printout from office issuing payments (SS, SSDI, unemployment, VA, etc.)
- Employer statement for cash wages (must include employer name, address and phone number)
- Award letter

Front Office Use Only:

Attesting patient declined to sign application: Staff Signature: _____ Date: _____

Guarantor #: _____

Application Received/Entered: Date: _____ By: _____

Self-Reported Household Size: _____

Self-Reported Household Income: \$ _____

Sliding Fee Scale Level Pre-Approved: Nominal A B C D Full Fee

90 Day Waiver Eligibility:

Does the patient report one or more of the following: Yes No

- Homeless
- Recent loss of income
- Resides in Public Housing
- Filed for Bankruptcy
- Other income issue reported: _____

Patient is required to bring in written proof of homelessness, income loss, public housing, bankruptcy, etc.

Staff with the Billing Manager and/or Executive Director for approval after receiving written proof.

Set the Financial Investigation income at \$0 (unless other amount is reported).

Examples of written proof:

- Homeless (Letter on letterhead from a local shelter or community provider attesting homelessness)
- Recent loss of income (Letter on employer letterhead or Unemployment Letter of Determination)
- Resides in Public Housing (Housing Lease or recent utility statement in person's name)
- Filed for Bankruptcy (County Court Filing form)

Finance Office Only:

Sliding Fee Scale Level Approved: Nominal A B C D Full Fee

Patient Notified of SFS Amount: Date: _____

At office/in person Reached patient by phone Attempted by phone /unable to reach patient

Revised: 10/2/2020

Patient Name: _____

ID #: _____