CAPITAL AREA cahn HEALTH NETWORK

Revised: 2/12/2019

CAPITAL AREA HEALTH NETWORK SLIDING FEE SCALE ELIGIBILITY DOCUMENTATION FORM

Patient Name: ____ Patient Date of Birth: ________

Patient Social Security Number: _______________________________ New Patient: ❑ Yes ❑ No

Patient Phone: (_________)____________________________________ Date of Application: _________

Guardian Name (if patient is a minor): ___________________________ Guardian SSN: ______________

It is the policy of Capital Area Health Network (CAHN) to provide health care services to its patients at a cost that is affordable for its patients who are uninsured or under-insured. This policy is designed to reduce barriers to access health services (including pharmacy services*) for such patients. In order to provide health care services at an appropriate fee for those patients who qualify for the Sliding Fee Scale Program (discounted scale), CAHN must know and document each patient's financial income. This policy ensures that no patient will be denied health services due to an individual's inability to pay for such services. **All applications must include all household members and all household income**. Please note, if you do not enroll in the Sliding Fee Scale Program, you are responsible for the full-amount of your office visit.

DECLINE APPLICATION FOR SLIDING FEE SCALE

I have been informed of the sliding scale and decline my right to apply for the sliding scale discount program. ____

Signature of Responsible Party Date

Patient's (or Guardian's) Annual Income: __________________ Patient's (or Guardian's) Family Size: ________

Household Size (those living with you)		*include additional household members on the back
Name	**Date of Birth**	**Social Security Number (SSN)**
1.		
2.		
3.		
4.		
5.		

Household Income			
Name	**Amount**	**Frequency (circle one)**	**Employer**
1. Applicant	$	Bi-Weekly Monthly Yearly	
2. Spouse/Partner	$	Bi-Weekly Monthly Yearly	
3. Children	$	Bi-Weekly Monthly Yearly	
4. Other	$	Bi-Weekly Monthly Yearly	
5. Other	$	Bi-Weekly Monthly Yearly	
6. **TOTAL**	$	Bi-Weekly Monthly Yearly	

Slide Fee Scale for Medical/Mental Health

Slide	Co-pay
Nominal	$36
A	$45
B	$60
C	$85
D	$110
Full Fee	Full Fee

Slide Fee Scale for Basic Dental Services

Slide	Co-Pay
Nominal	$60
A	$90
B	$100
C	$110
D	$120
Full Fee	Full Fee

Office Use Only: **Medical:** Nominal A B C D Full Fee **Dental:** Nominal A B C D Full Fee

Other Income	Applicant	Spouse	Children	Other	Subtotal
Employer Report Letter – Income Statement					
TANF Letter or Food Stamp Notice of Action Letter					
1040 Tax Form with all corresponding W-2 for most recent calendar year					
Statement of Social Security Benefits (SSI, SSDI, SSRI)					
Self Employed Wage Documentation (Schedule C)					
Notarized Child Support Verification Letter					
Current Statement of Alimony					
Unemployment Benefits					
Workers Compensation Benefits					
Local cash assistance benefits					
Pension of Annuities					
Cash amounts received or withdrawn from any source including savings, investments, trust accounts, or other resources readily available					
Notarized Patient Report Letter – Income Statement, signed and witnessed by a staff member					
Military Leave and Earnings Statement					
Other: ______________________________					

Laboratory Services: Sliding fee scale patients will be charged $15 for lab test(s) and full fee for vaccinations.

***Pharmacies:** Walgreens and Kroger's are Capital Area Health Network's preferred pharmacies. For additional information and a listing of all the pharmacies CAHN has partnered with, please request such information from CAHN's staff.

By signing this document, I acknowledge that I have read, understand and agree to the terms and conditions of this form. I understand that I will be bound by these terms and agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I understand that this documentation will expire one (1) year from date of signature. I understand that I am responsible for contacting Capital Area Health Network if my eligibility status has changed. I understand if I do not wish to comply with the sliding fee scale policy and disclose my income status at the time of my initial visit, I will be registered as a full paying patient.

Signature of Patient or Responsible Party: ______________________________Date: ____________________

Printed Name of Patient or Responsible Party: ____________________Relationship (if not self): ___________

For office use only:

Date Application Completed: _____________________ Date Documents Received: ________________

Application and Documents Reviewed by: ____________________________________