Mountain Valleys Health Centers

Sliding Fee Discount Program Policy Statements

- Patients shall receive and acknowledge receipt of MVHC's Sliding Fee Discount Program Policy.
- The Sliding Fee Discount Program shall be offered to all MVHC patients with or without insurance.
- MVHC must gather personal information in order to give a discount on medical/dental services. This information will be held in strict confidence.
- All income must be reported and used to determine eligibility for the Program. Changes to income or family size are required to be reported to MVHC.
- Patients must verify income and family size every twelve months.
- Following are some examples of documents that show proof of income:

  * W-2 form
  * Pay Stubs (2)
  * 1099G (Unemployment benefits)
  * Letter from an employer
  * Tax Return (required for self-employed earnings)
  * Social Security/SSI benefit statement letter
  * Bank statement (showing direct deposit by name)
  * Unemployment Stub

- **Patients declining to be assessed for eligibility in the Sliding Fee Discount Program by refusing to provide the required information are not eligible for the Sliding Fee Discount Program.**
- Patients unable to provide proof of income because no reasonable option for providing it exists, must complete a *Self-Declaration of Income Statement* to be approved by the Site Manager or the COO.
- Patients have 30 days from the date of service to submit a completed application with proof of income. Until required documents have been submitted and eligibility has been determined the patient is responsible for full fees. If the patient applies at a later time, **eligibility is not retroactive.**
- Payment is expected at time of service. Please note that payment in full at time of service will qualify for an additional discount - 10% for dental/medical, 15% for 65 and over **dental only**.

  Please acknowledge receipt of this policy by signature designated on the Sliding Fee Discount Program Application. Please retain this Policy for your records.

Mountain Valleys HEALTH CENTERS

Sliding Fee Discount Program Application

Name:	**Date of Birth**

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes ☐ No ☐ If yes, please list below:

Definition of Family Size: "Family size" shall be determined by considering, as a group, any related or nonrelated individuals living together whose production of income and consumption of goods are co-mingled. In addition, a single individual living alone shall be counted as one person for "family size" for purposes of the sliding fee. Please answer the following based on this definition of family size.

Family size: _____

***Besides Yourself,* Give Name and Date of Birth for all individuals included in the family size. Please indicate if they are a current patient by circling yes or no.**

Name	Date of Birth	Current Patient
		Yes or No
		Yes or No
		Yes or No
		Yes or No
		Yes or No
		Yes or No

How often do you get paid? ☐ Weekly ☐ Bi-Weekly ☐ Twice Monthly ☐ Monthly

Definition of Income: Income is the total amount of annual money income each individual received before payments for income taxes, social security, Medicare deductions, etc. Please answer the following based on this definition of income.

For *Everyone* in your household, please list the gross income (before taxes) based on the aforementioned definition of income.

Wages:	**Public Assistance:**
Social Security/SSI:	**Rental Income:**
Unemployment:	**Interest Income:**
Disability/Workers Comp.:	**Education Assistance:**
Retirement/Pension:	**Child Support, Alimony:**
Self-Employment (Tax Return Required):	**Other (specify):**

- I acknowledge that I received and understand the MVHC Sliding Fee Discount Program Policy.
- I declare the above information is true and correct. I understand that this information will be kept in strict confidence. I understand if my income or "family size" should change, I am required to notify MVHC on my next visit to the health center. I understand that giving false information will result in the denial of discount benefits and that I will be responsible for the full fee and no longer eligible for the Sliding Fee Discount Program.

Applicant's Signature: _____ Date: _____

For Office Use Only

Date of Service: _____ Application received by: _____ Date: _____ W/I 30 Days Y N

Reviewed by: _____ Date _____ Supervisor Approval (for Self-Declaration) _____

Mountain Valleys
HEALTH CENTERS

Self-Declaration of Income Statement

Name: _____ DOB: _____

I am unable to provide proof of income and must self-declare my income by completing this form. I understand that I must report any income I received during the twelve months prior to the date of this declaration.

Sources and amounts of income listed in the application for which I have no proof:

Source: _____ Amount for the last 12 months: _____

Reason I cannot provide proof:

_____

_____

Source: _____ Amount for the last 12 months: _____

Reason I cannot provide proof:

_____

_____

Source: _____ Amount for the last 12 months: _____

Reason I cannot provide proof:

_____

_____

Source: _____ Amount for the last 12 months: _____

Reason I cannot provide proof:

_____

_____

If you declared zero income please explain your current living situation and how your monthly expenses are met.

_____

_____

_____

I declare the above information is true and correct. I understand that this information will be kept in strict confidence. I also understand that if my income or "family size" should change, I am required to notify MVHC on my next visit to the health center. I understand that giving false information will result in the denial of discount benefits and that I will be responsible for the full fee and no longer eligible for the Sliding Fee Discount Program.

Patient Signature _____ Date _____

Self-Declared income must be approved by the Team Lead, COO or Billing Manager (signature acknowledging approval is required on the Sliding Fee Application).