HCHC
HEALTHY COMMUNITY HEALTH CENTERS

SLIDING FEE DISCOUNT PROGRAM

Welcome to the Harrisonburg Community Health Center. We offer affordable health care and dental care through the use of the sliding fee discount program to uninsured and underinsured qualified individuals and families. Eligibility is based on family size and family income. *Our mission is to be a leading provider of quality health care for our diverse community.*

HCHC's Sliding Fee Discount Program Scale is based on the definition of federal poverty provided by the Department of Health and Human Services annually and is divided into four categories: A,B,C,D, and E with fees as follows:

Categories	*Income Level*	*Medical fees per visit*	*Dental Fees per visit*	*Mental health fees per visit*	*Title X*	*Prenatal*
Slide A	*100% FPL and below*	*$15*	*$80 Basic services $500 Complex services*	*$10*	*$0*	*$300*
Slide B	*101-150% FPL*	*$25*	*$90 Basic services $600 Complex services*	*$15*	*$25*	*$420*
Slide C	*151-175% FPL*	*$35*	*$100 Basic services $700 Complex services*	*$20*	*$35*	*$510*
Slide D	*176-200% FPL*	*$45*	*$110 Basic services $800 Complex services*	*$25*	*$45*	*$600*
Slide E	*201% FPL*	*Full Fee*	*Full Fee*	*Full Fee*	*Full Fee*	*Full Fee*

There is no charge for Lab visits regardless of the number of tests completed at that visit, for patients eligible for sliding fee discounts unless the patient also has commercial insurance. The insurance will be billed by the lab processing vendor for those patients and any unpaid balance will be the patient's responsibility. The Sliding Fee Discount application needs to be renewed every year. Members of the family are defined as the head of household, any spouse, custodial parent(s) and all financial dependents. Dependents are those individuals the applicant is legally obligated to support.

Applicants **MUST** provide proof of all sources of income that apply for the last 30 days.

CHECK ALL sources of proof of income that applies:

- ☐ *1040 Tax Forms (no W2's)*
- ☐ *Social Security / Disability Letter*
- ☐ *Unemployment Benefit Letter (no bank statements)*
- ☐ *Letter of support*
- ☐ *Pension Benefit Letter*
- ☐ *Inheritance*
- ☐ *Trust Funds*
- ☐ *Veterans Benefits*

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☐ *Employers letter (if paid in cash)*

☐ *Wages (if paid weekly the last 4 paystubs, if paid bi-weekly the last 2 paystubs)*

SLIDING FEE DISCOUNT APPLICATION

Applicant's full name:	Social Security Number:
Mailing Address:	Date of Birth:
City, State, Zip	Primary phone number:

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD

Full Name	Date of Birth	HCHC Dental Patient	HCHC Medical Patient	Dental Insurance	Medical Insurance
		Yes No	Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No	Yes No

Has the applicant been screened for the **Market Place**, **Medicaid** or other **assistance** by the Department of Social Services?

YES	NO	If yes, which one and why does the patient not receive the above aid?

Would you like to apply?

YES	NO	If no, explain why

AFFIDAVIT: *By signing, I attest that as of the date of my signature, the income sources listed are all of my household income, the household members listed are all solely dependent on that income, and the documentation that I provided to verify my income level is true.*

I understand that if the information provided is found to be incomplete or fraudulent I will be removed from the sliding scale permanently.

Applicant/Responsible party signature ***Date***

For Office Use Only
Valid Until: _____ Staff Initials: _____ Slide:_____ Self Dec. Application: Y / N


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