There is Help Available to Pay for your Health Care:

The Community Health Net's Sliding Fee Discount Program

Family Size	Discount A $25.00* *nominal fee		Discount B $35.00		Discount C $45.00		Discount D $55.00		Full Fee 100%
	From	To	From	To	From	To	From	To	
1 Person									
Annually	$0	$15,060.00	$15,060.01	$20,180.40	$20,180.41	$25,150.20	$25,150.21	$30,120.00	$30,120.01
Weekly	$0	$290	$290	$388	$389	$484	$485	$579	$580
2 Person									
Annually	$0	$20,440.00	$20,440.01	$27,389.60	$27,389.61	$34,134.80	$34,134.81	$40,880.00	$40,881.00
Weekly	$0	$393	$393	$527	$528	$656	$657	$786	$787
3 Person									
Annually	$0	$25,820.00	$25,820.01	$34,598.80	$34,598.81	$43,119.40	$43,119.41	$51,640.00	$51,641.00
Weekly	$0	$497	$497	$665	$666	$829	$830	$993	$994
4 Person									
Annually	$0	$31,200.00	$31,200.01	$41,808.00	$41,808.01	$52,104.00	$52,104.01	$62,400.00	$62,401.00
Weekly	$0	$600	$600	$804	$805	$1,002	$1,003	$1,200	$1,201
5 Person									
Annually	$0	$36,580.00	$36,580.01	$49,017.20	$49,017.21	$61,088.60	$61,088.61	$73,160.00	$73,161.00
Weekly	$0	$703	$703	$943	$944	$1,175	$1,176	$1,407	$1,408
6 Person									
Annually	$0	$41,960.00	$41,960.01	$56,226.40	$56,226.41	$70,073.20	$70,073.21	$83,920.00	$83,921.00
Weekly	$0	$807	$807	$1,081	$1,082	$1,348	$1,349	$1,614	$1,615
7 Person									
Annually	$0	$47,340.00	$47,340.01	$63,435.60	$63,435.61	$79,057.80	$79,057.81	$94,680.00	$94,681.00
Weekly	$0	$910	$910	$1,220	$1,221	$1,520	$1,521	$1,821	$1,822
8 Person									
Annually	$0	$52,720.00	$52,720.01	$70,644.80	$70,644.81	$88,042.40	$88,042.41	$105,440.00	$105,441.00
Weekly	$0	$1,014	$1,014	$1,359	$1,360	$1,693	$1,694	$2,028	$2,029

Community Health Net is a Federally Qualified Health Center (FQHC)

As a FQHC, we are able to offer a discount on services based on income and family size. We use the above table to determine your discount eligibility.
(This table can be located at https://aspe.hhs.gov/poverty-guidelines)

What services are included in the program?

- Primary care visits at Community Health Net
- Behavioral health visits at Community Health Net
- Eye clinic visits at Community Health Net
- Dental care visits at Community Health Net
- CHN Pharmacy (see Pharmacy for eligible items)

What kinds of services are NOT included in the program?

- Hospital Visits, Hospital Services, Nursing Homes
- Imaging facilities (x-rays, CT, MRI, etc.)
- Laboratories (ACL, etc.)
- Some dental procedures: partials, dentures, crowns, or items produced at an offsite lab

Call Today
to learn more!

814-455-7222
or
814-454-4530

Sliding Fee Discounts are determined by using examples of the following:

- Federal Income Tax forms
- W-2's
- Consecutive Pay stubs
- Unemployment Benefits
- Social Security Benefits
- Self-declaration options are also available

Recertification is required annually or when changes to family size or income occur. Once you have been approved for the Sliding Fee Discount Program, you will

COMMUNITY Health Net
Everyday people Extraordinary care

Sliding Fee Discount Program Enrollment Opportunity

It is the policy of Community Health Net to provide services regardless of the patient's ability to pay. As a Federally Qualified Health Center, Community Health Net offers a Sliding Fee Discount Program designed to allow patients to pay for healthcare services based on family size and income; therefore, patients earning less money will pay less than those that earn more. The discount will apply to services received at all Community Health Net locations. Some exclusions apply.

This program is offered to all Community Health Net patients – employed, self-employed, unemployed, retired, insured, uninsured, etc. Your personal information will not be reported to any outside entity without your written consent. You receive the same quality care and services whether you receive the discounted rates or not. When you apply to participate in this program, we will review your application based on the Federal Poverty Guidelines published annually by the Federal Government to determine which category best applies to the amount you pay for your services.

Name: _____

Current Address: _____

Email: _____ Phone: _____

Select One:

☐ I am applying to participate in the Sliding Fee Discount Program and requesting Community Health Net review my application and income information. I certify that the information provided is correct to the best of my knowledge. If approved, I agree to notify Community Health Net if there are any changes in my household size or income and understand that I must requalify annually to maintain eligibility.

☐ I am enrolled in the Sliding Fee Discount Program and requesting annual renewal or making a change.

☐ I am **not** interested in applying for the Sliding Fee Discount Program but understand I may elect to apply at any time by contacting Community Health Net. Declination MUST be signed every calendar year.

Please list the names of **ALL** household members including self			Date of Birth:
First Name:	Middle Name/Initial:	Last Name:	MM/DD/YYYY

_____

Signature **Date**

TO BE COMPLETED BY COMMUNITY HEALTH NET STAFF

Household Size: _____ Annual Income: $ _____

☐ Income verified
☐ Entered in to NextGen

CHN Employee Processing Application: _____

Date Application Processed: _____

Finance Department Approval: _____

Discount Rate Approved For:
A B C D

Copay Amount Approved For:
$ _____

Effective Date: _____

Expiration Date: ** 365 days from Effective Date**

Date of Finance Approval: