

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	\$15,960.00	\$15,960.01	\$21,386.40	\$21,386.41	\$26,653.20	\$26,653.21	\$31,920.00	\$31,920.01
Weekly	\$0	\$307	\$307	\$411	\$411	\$513	\$513	\$614	\$614
2 Person									
Annually	\$0	\$21,640.00	\$21,640.01	\$28,997.60	\$28,997.61	\$36,138.80	\$36,138.81	\$43,280.00	\$43,280.01
Weekly	\$0	\$416	\$416	\$558	\$558	\$695	\$695	\$832	\$832
3 Person									
Annually	\$0	\$27,320.00	\$27,320.01	\$36,608.80	\$36,608.81	\$45,624.40	\$45,624.41	\$54,640.00	\$54,640.01
Weekly	\$0	\$525	\$525	\$704	\$704	\$877	\$877	\$1,051	\$1,051
4 Person									
Annually	\$0	\$33,000.00	\$33,000.01	\$44,220.00	\$44,220.01	\$55,110.00	\$55,110.01	\$66,000.00	\$66,000.01
Weekly	\$0	\$635	\$635	\$850	\$850	\$1,060	\$1,060	\$1,269	\$1,269
5 Person									
Annually	\$0	\$38,680.00	\$38,680.01	\$51,831.20	\$51,831.21	\$64,595.60	\$64,595.61	\$77,360.00	\$77,360.01
Weekly	\$0	\$744	\$744	\$997	\$997	\$1,242	\$1,242	\$1,488	\$1,488
6 Person									
Annually	\$0	\$44,360.00	\$44,360.01	\$59,442.40	\$59,442.41	\$74,081.20	\$74,081.21	\$88,720.00	\$88,720.01
Weekly	\$0	\$853	\$853	\$1,143	\$1,143	\$1,425	\$1,425	\$1,706	\$1,706
7 Person									
Annually	\$0	\$50,040.00	\$50,040.01	\$67,053.60	\$67,053.61	\$83,566.80	\$83,566.81	\$100,080.00	\$100,080.01
Weekly	\$0	\$962	\$962	\$1,289	\$1,289	\$1,607	\$1,607	\$1,925	\$1,925
8 Person									
Annually	\$0	\$55,720.00	\$55,720.01	\$74,664.80	\$74,664.81	\$93,052.40	\$93,052.41	\$111,440.00	\$111,440.01
Weekly	\$0	\$1,072	\$1,072	\$1,436	\$1,436	\$1,789	\$1,789	\$2,143	\$2,143

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
- Prescriptions filled at Community Health Net (see Pharmacy for restrictions)

What 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

Sliding Fee Discounts can be determined by using any of the following (or combination):

- 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 remain active in the program for **one year from application approval.**





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:	MM/DD/YYYY
Middle Name/Initial:	
Last Name:	

Signature

Date

****Renewals MUST be completed annually on effective date****

****You will be notified by mail of the application results****

CHN Staff:

- * If applying please collect pay information and / or self declaration. Once received send to Finance.
- * If patient declines, send to Medical Records.
- * If patient applies but does not provide documentation, follow up with patient within 7 days.

Staff person doing F/U _____

Follow up date: _____ If patient no longer wants to apply, _____
initial and date here: