

FAMILY HEALTH NETWORK OF CENTRAL NEW YORK, INC.

SLIDING FEE POLICY

Family Health Network offers a sliding fee adjustment for patients and members of their families (defined below) who fall below 200% of the poverty guidelines as set forth in the Federal Register. Income levels are based on total "family" income; "family" is defined below. The amount of the discounts and the income ranges for those discounts are fixed by the Board of Directors and approved by the Federal Grants Management Office, Region II. Income guidelines are revised annually. Current discounts and income guidelines are outlined on the back of the sliding fee application and are available at all Family Health Network (FHN) sites.

DEFINITIONS

Family: A family means those persons within the same household (including their dependents/partner) who are applying for the sliding fee discount using their combined income.

Individual: An individual is a person 15 years old or over who has verifiable income using the list below. (*)

INCOME VERIFICATION

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify FHN of that change. FHN reserves the right to verify income with an employer at any time.

(*)Patients are required to give at least one of the following items as verification of income:

1. Previous year tax return
2. Previous year W-2
3. Current pay stubs (last 4 weeks, if possible)
4. Lay-off notice from last employer
5. Current information from Unemployment Office
6. Denied Medicaid application and reason for denial
7. Check stubs from Unemployment (last 4, if possible)

ELIGIBLE FEES

Primary Medical and Dental services provided at the centers are eligible for the sliding fee. **Co-pays, previous charges, supplies, medical and dental lab charges, medical x-ray and any other outside services, and ear piercing are NOT ELIGIBLE for a sliding fee discount. Deductibles ARE eligible for sliding fee.**

MINIMUM CHARGE

There is a minimum medical and dental charge for all sliding fee visit, as approved by the Board of Directors. The minimum charge **MUST** be paid at time of service regardless of insurance coverage.

PAYMENT FOR SLIDING FEE VISITS

Payment is required when services are rendered. Your sliding fee deduction goes into full effect only after you have submitted all required income verification and you are determined to be eligible. We will slide one visit per family per year without income verification.

April 1999

Revised 8-15-01

Board approval on 8-15-01

Reviewed 1-21-02

Revised 7-25-07

Family Health Network of CNY
Patient Information and Insurance Form

1. Patient's Name _____ Today's date _____
2. Home Address _____ City _____
 State _____ County _____ Zip code _____
3. Sex: Female Male
4. Date of Birth _____ Social Security No. _____
5. Home phone _____ Work No. _____ Emergency phone _____
6. Who is emergency contact? Name _____ Relationship to patient _____
7. Marital status of patient: Single Married Separated Divorced Widowed
8. Employer/School _____ Occupation _____
9. Employer's Address _____

Because Family Health Network of CNY is federally funded, we are required to collect the information asked in questions 10 through 12. This information is used for statistics only, without anyone's name attached to it and will remain confidential. Reporting these statistics to the federal government enables Family Health Network of CNY to continue to receive funding for the services we provide. Thank you for your cooperation.

10. Race: Caucasian Afro-American Asian Hispanic/Latino Pacific Islander
 Native American Other (please specify) _____

11. Please place a check mark under the amount(s) of your annual household income range.

Below \$10,210	\$10,210- \$15,699	\$15,700- \$20,699	\$20,700- \$25,799	\$25,800 \$30,399	\$30,400- \$36,799	\$36,800- \$42,199	\$42,200- \$47,999	\$48,000 and over
_____	_____	_____	_____	_____	_____	_____	_____	_____

12. Number of people in your household _____
 _____ for office use/initials

13. **Financially Responsible Party** _____

Name _____ Date of birth _____ Relationship to patient _____
 Social Security No. _____ Home Address _____
 City _____ State _____ Zip code _____ Home phone _____

IMPORTANT

PLEASE READ BELOW and SIGN

I authorize the release of any medical information necessary to process billing to my designated health insurance company (ies) and make payment to Family Health Network of CNY. If your insurance company (ies) pays you directly for the services provided by Family Health Network of CNY, it is your responsibility to forward the payment to Family Health Network of CNY. Failure to forward the payment is insurance fraud. If an account is forwarded to a collection agency, you will be responsible for all the balances due, collection fees and or legal fees. My signature below indicates my understanding and acceptance of the above release of information and payment policies as stated above.

Signature _____ Date _____ Witnessed _____

For Office Use Only: Copy of card(s) taken Yes ___ Unavailable ___
 All information entered in system date _____ by (signature) _____

16. Income: List income for the family from:

	Current Monthly	Last 12 month Total
Wages or self employed	_____	_____
Public Assistance or Social Security	_____	_____
Unemployment or Worker's Compensation	_____	_____
Alimony or Child Support	_____	_____
Pensions	_____	_____
Rental property, Dividends, Interest, and other income...	_____	_____

17. Are you eligible for Medicaid? _____

18. Do you have any other Insurance? _____ If so what kind? _____

19. Family Size:

Name	Date of Birth	Relationship

I have read the Sliding Fee Policy and I understand that payment is due at the time of service.

Date: _____ Signature: _____

~ VERIFICATION OF INCOME REQUIRED ~

Please send either: 4 weeks' pay stubs, unemployment verification, or last years Income

Tax W-2 or 1040.

ATTENTION: If documents of income verification are not given to us within 14 days of this application the application will no longer be good and you must reapply. Thank you for your cooperation in advance.

FOR OFFICE USE ONLY

Qualifies for: _____ % Discount _____ Ineligible

Date of determination: _____

Signature of person making eligibility determination: _____