



Financial Assistance Sliding Fee Discount Program Information

What is the Sliding Fee Discount Program?

It is the policy of Heartland Health Services to provide patient-centered primary care regardless of the patient's ability to pay. Discounts are offered based upon household income and the number of immediate members in the household. A sliding fee schedule is used to calculate the basic discount and is updated each year using federal poverty guidelines. Once approved, the discount will be applied to services, between 3 months and 12 months if approved, after which the patient must reapply.

The Sliding Fee Discount Program is part of a federal program (Federally Qualified Health Centers – FQHC) that allows Heartland Health Services to discount normal charges for medical visits for our qualifying patients based on household size and household income. In order to qualify for the program, patients must provide proof of income below 200% of the current federal poverty level.

The Sliding Fee Discount Program is available to all uninsured patients. If you have insurance coverage, Heartland Health Services is required by the FQHC program to bill your insurance for your medical/behavioral health visit charges. You may be responsible for insurance co-payment in this situation. If you have co-insurance or a high deductible, you may apply for the Sliding Fee Discount to apply to the patient responsibility portion of the charges.

Depending on the household size and household income, patients are assigned a discount tier of full fee, Category A, Category B, Category C or Category D. The minimum fee charged for each tier is shown below:

Discount Tier	Category A	Category B	Category C	Category D	Full Fee
Medical Minimum Fee	\$25.00	\$30.00	\$35.00	\$40.00	100% of Charge(s)
Behavioral Health Minimum Fee	\$5.00	\$10.00	\$15.00	\$20.00	100% of Charge(s)

Patients that qualify for the discounted fees are responsible only for the minimum fee in their respective tier and are expected to pay the discount fee at the time of service.

How do I sign up for the Sliding Fee Discount Program?

1. First, complete the Financial Assistance (FA) application included with this information packet. Instructions are included on the application. Please feel free to ask front desk personnel if you have any questions or need assistance completing the application.
2. Attach proof of income – Examples of acceptable proof listed below (copies are acceptable):
 - Prior 2 months of consecutive Pay-stubs
 - Prior 2 months of consecutive Bank Statements
 - Income Tax Return for the most recent year
 - Unemployment Verification (Benefit Statement)
 - Court Documents (Alimony and/or Child Support)
 - Benefit Letter (SSI and Social Security recipients, Pension/Retirement recipients)
 - Rents and/or Royalties Received
 - In case of no income, provide a letter of survival (tell us how you meet your day-to-day needs)
 - Self-Employed - provide your most recent year Income Tax Return
 - If no pay-stubs available, applicants employer must provide a letter indicating current gross income for each pay period
3. Submit your COMPLETED IN FULL application with attached proof at any of our Heartland Health Services clinics or mail completed information to:

Heartland Health Services
Attn: Financial Assistance
2214 N University St
Peoria, IL 61604

5. If you have any questions about or completing the financial assistance application, please contact Celia at 309-680-7631.
6. Please Note: Financial Assistance Applications will only be retroactive effective 90 days from the date of applications receipt or approval.

Include anyone at least 18 years of age or older who resides in the household and contributes to the basic living expenses of the household (including yourself). Income includes gross (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, pensions and/or IRA distribution income or other retirement income. (See instruction for complete list) DO NOT include non-cash assistance such as food stamps, housing allowance, or other government subsidies.

HOUSEHOLD EARNINGS INFORMATION - Please indicate ALL people living in your household who contribute financially, including applicant

Household Member(s)	Age	Source of Income/Employer	Monthly Gross Income
1			\$
2			\$
3			\$
4			\$
5			\$
6			\$

Total Monthly Income (Include total from Benefits, bottom of page 1) \$ _____

Do you have health insurance? Yes No

If yes, please list the health insurance carrier and the subscriber ID#

If unemployed and have no income, how do you meet your day-to-day needs?

My signature below represents that the above information is true and correct. I understand that more information may be requested from me if needed. I understand that any falsification of the information, I have provided to Heartland Health Services, will result in termination of all financial assistance.

Signature of Patient/Guardian _____ Date Signed: _____

Signature of HHS Employee _____ Date Received: _____