# Sliding Fee Discount Program Financial Assistance Application

It is the policy of Heartland Health Services to provide patient-centered primary care regardless of the patients' ability to pay. Discounts are offered based upon family income and family size. Our sliding fee schedule is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for three months to one year from the approval date (depending on income). The patient may reapply any time prior to or after the expiration of the discount period.

A completed application, including verification of family income and family size, must be filed and approved by Heartland Health Services before a discount is applied.

Please complete the following information:

| **DEMOGRAPHICS** | **PATIENT / APPLICANT** | **GUARANTOR/GUARDIAN (If Applicable) (Responsible for paying the bill)** |
|---|---|---|
| Last Name: | | |
| First Name, MI: | | |
| Date of Birth: | | |
| Address: | Street: | Street: |
| | City: | City: |
| | State: | State: |
| | Zip Code: | Zip Code: |
| Primary Phone #: | | |

| **SECTION 1:** | **HOUSEHOLD SIZE INFORMATION (List all Individuals in your household)** | |
|---|---|---|
| Name(s) | Date of Birth | Relationship to Guardian |
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

*Please add additional individuals/dependents on a separate sheet, if more space is needed*

| **SECTION 2:** | **FAMILY/HOUSEHOLD INFORMATION** | |
|---|---|---|
| **Did you file Income Taxes last year?** | **Yes** | **No** |
| Did you or your spouse receive: Unemployment Benefits, Social Security Retirement, Social Security Disability, or a Pension? If you answered **YES** for any of these, list what benefit is received and how much per month? | | |
| Benefit Type | | Amount per Month |
| 1 | | $ |
| 2 | | $ |
| 3 | | $ |
| 4 | | $ |

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.

| **SECTION 3:** | **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?

_____

_____

_____

_____

_____

***** PLEASE MAKE SURE TO INCLUDE ALL REQUIRED DOCUMENTS BEFORE SUBMITTING *****

**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: _____

# 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 Siding 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, instructions are included on each section of the application. Please feel free to ask front desk personnel if you have any questions or need assistance completing the application.
2. Attach income information for all household members who contribute financially – your application will not be considered without the following:

   **REQUIRED at least 2 forms of income (COPIES ONLY)**:

   - Prior 2 months of consecutive Pay-Stubs - (we need at least 8 weeks of back to back pay-stubs if you are paid every week or we need at least 4 back to back pay-stubs if you are paid every 2 weeks)
   - Income Tax Return for the most recent year - (must be included in documents)
   - Unemployment Verification (Benefit Statement)
   - Benefit Letter (SSI and Social Security recipients, Pension/Retirement recipients)
   - 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
   - In case of no income, provide a letter of survival (tell us how you meet your day-to-day needs)

   **Additional Information to Provide (as applicable) Include:**

   - Prior 2 months of consecutive Bank Statements
   - Court Documents (Alimony and/or Child Support)
   - Rents and/or Royalties Received

3. Submit your COMPLETED application with attached proof of income (copies only) at any of our Heartland Health Services clinics or mail all completed documents to:

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

4. If you have any questions about or completing the financial assistance application, please contact Celia at 309-680-7631.

5. Please Note: Financial Assistance Applications will only be retroactive effective 90 days from the date of applications receipt or approval.

# FINANCIAL ASSISTANCE APPLICATION - CHECK LIST

**Please include a copy of all the items below with your application – Do not include original copies.**

| **Application:** | **Completed Y / N / NA** |
|---|---|
| Verified as fully completed - each section is filled out<br>o Demographics<br>o Section 1<br>o Section 2<br>o Section 3 | |
| Patient Signature & Dated | |
| HHS Employee Signature & Dated (Once completed application is received) | |

**Required – Proof of Income (all documents verified)**

| | |
|---|---|
| Prior 2 months of consecutive paystubs | |
| Income Tax Return for the most recent year | |
| If unemployed, Unemployment Verification (Benefit Statement) | |
| Benefit Letter(s) (SSI & Social Security recipients, Pension/Retirement recipients) (if applicable) | |
| Self-Employed – provide your most recent year Income Tax Return | |
| If no pay-stubs available - MUST have a letter from employer indicating current gross income for each pay period | |
| If unemployed, Letter of survival if no income (how do they meet day-to-day needs) | |

**Additional Information to Provide (as applicable) Include:**

| | |
|---|---|
| Prior 2 months of consecutive bank statements | |
| Court Documents (Alimony and/or Child Support) (if applicable) | |
| Rents and/or Royalties Received (if applicable) | |

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**For Office Use Only:**

MRN: _____

Name of Heartland Employee receiving this information

| | |
|---|---|
| _____ | _____ |
| Print Employee Name: | Date Received & Verified: |