Green River Medical Center Sliding Fee Discount Application

SLIDING SCALE ELIGIBILITY DECLARATION/*DECLARACION de ELIGIBIDAD de ESCALA de DESCUENTO*

Family Information (must be completed for all applicants)/*Informacion de la familia (debe ser llenada por todos los que aplican)*

# of Family Members / # de Miembros de su Familia:_____ OFFICE USE ONLY FAMILY ACCT#:

HOUSEHOLD COMPOSITION

List all family member names and account numbers / Enliste todas los miembros de su familia:

	OFFICE USE ONLY
1. Name/Nombre:_____ DOB:_____	ACCT#
2. Name/Nombre:_____ DOB:_____	ACCT#
3. Name/Nombre:_____ DOB:_____	ACCT#
4. Name/Nombre:_____ DOB:_____	ACCT#
5. Name/Nombre:_____ DOB:_____	ACCT#
6. Name/Nombre:_____ DOB:_____	ACCT#
7. Name/Nombre:_____ DOB:_____	ACCT#
8. Name/Nombre:_____ DOB:_____	ACCT#

HOUSEHOLD INCOME (proof of income must be copied and attached)

Employer: _____

Gross wages per pay period: $ _____

How often are you paid? (check one) □ DAILY □ WEEKLY □ Twice/month □ Monthly □ OTHER:_____

*OTHER INCOME Please indicate amount and frequency of receipt: $*_____ *per* _____
(Amount) (week, month, etc.)

List other income from all source, which may incude self-employment wages, tips, unemployment benefits, Social Security, SSI, child support, public assistance (TANF), housing allowance, military family allotments, pension benefits, VA benefits, trust fund disbursements, training stipends, scholarships, grants, food stamps, and all other forms of financial support.

SELF-DECLARATION/SOCIAL VERIFICATION (must be completed if no proof is attached)

Employer: _____

Gross wages per pay period: $_____

How often are you paid? (check one) □ DAILY □ WEEKLY □ Twi GROSS MONTHLY EARNINGS: $_____

Self-declaration will be accepted for sliding fee purposes on the <u>first</u> visit only. All subsequent visits wil be charged at the full fee unless proof of income is provided.

AFFIDAVIT

By signing below, I attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the family members listed are all solely dependent on that income, or that the explanation provided to verify my income level is truthful.

Al firmar esta forma yo testifico, que desde la fecha de mi firma, la prueba de ingreso presentada constituye todo mi ingreso economico y que los miembros de mi familia depend de elle : o que la explicacion dada para verificar mi nivel de ingreso es verdadera.

APPLICANT SIGNATURE/*FIRMA del APLICANTE:* _____ DATE:_____

SLIDING SCALE DISCOUNT (OFFICE USE ONLY)

Sliding Fee Scale (Circle one): 0% 20% 40% 60% 80% 100%

VALID FROM: _____ TO _____ OFFICE STAFF SIGNATURE:_____

GREEN RIVER MEDICAL CENTER
Sliding Fee Scale
Effective Date 06-22-16

Percent of Charges based on Income and Family Size

Nominal payment for patients 0-100% FPL = $25.00
No patient shall be turned away for an inability to pay.

% of visit charges	A-0% ($25 nominal payment)	B-20%	C-40%	D-60%	E-80%	Full charges
Poverty Level/ Family Size	0-100%	101-125%	126-150%	151-175%	176-200%	Over 200%
1	$0-$11,880	$11,881-$14,850	$14,851-$17,820	$17,821-$20,790	$20,791-$23,760	$23,761 & over
2	$0-$16,020	$16,021-$20,025	$20,026-$24,030	$24,031-$28,035	$28,036-$32,040	$32,041 & over
3	$0-$20,160	$20,161-$25,200	$25,201-$30,240	$30,241-$35,280	$25,281-$40,320	$40,321 & over
4	$0-$24,300	$24,301-$30,375	$30,376-$36,450	$36,451-$42,525	$42,526-$48,600	$48,601 & over
5	$0-$28,440	$28,441-$35,550	$35,551-$42,660	$42,661-$49,770	$49,771-$56,880	$56,881 & over
6	$0-$32,580	$32,581-$40,725	$40,726-$48,870	$48,871-$57,015	$57,016-$65,160	$65,161 & over
7	$0-$36,730	$36,731-$45,912	$45,913-$55,095	$55,096-$64,277	$64,278-$72,740	$72,741 & over
8	$0-$40,890	$40,891-$51,112	$51,113-$61,335	$61,336-$71,557	$71,558-$81,780	$81,781 & over
9	$0-$45,050	$45,051-$56,312	$56,313-$67,575	$67,576-$78,837	$78,838-$90,100	$90,101 & over
10	$0-$49,210	$49,211-$61,512	$61,513-$73,815	$73,816-$86,117	$86,118-$98,420	$98,421 & over

For each additional family member over 10, add $4,160.

Discounted Charges for Dental Services outside of scope for individuals at 0-100% FPL:

$20 on $0 - $100 in charges
$20 + 10% of charges for $101 - $200 in services
$20 + 15% of charges for $201 - $300 in services
$20 + 20% of charges for $301 - $400 in services
$20 + 25% of charges for $401 - $500 in services