

SLIDING FEE DISCOUNT PROGRAM APPLICATION

BETHEL FAMILY CLINIC

Date	
Patient Name	
Address	
Phone Number	

Bethel Family Clinic (BFC) defines a household as all individuals residing in the same home and sharing expenses. Household members include the patient, spouse, significant other, grandparents, children, foster children, and other dependents. Please list yourself and all members of your household you wish to include in your household size.

BFC uses your monthly gross income to determine eligibility for discounted services. The following documentation is required for eligibility. Approved proof of identity and income sources includes one or more of the following items:

- Adult Identification: driver’s license, identification card, or social security card
- Minor identification: may include birth certificate, identification card and/or social security card
- Income:
 - Paycheck stubs with year-to-date information
 - Most recent tax returns
 - Bank statements
 - Statement of income determinations from federal, state or local government (such as SSI letter)
 - BFC’s *No Proof of Income Worksheet*

First and Last Name	Age	Relationship to Patient	Monthly Income
		Self	\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
Total Household Income			\$

SLIDING FEE DISCOUNT PROGRAM APPLICATION, CONT.

I certify that the information given on this form and the provided income documentation is complete, true and correct. If I do not qualify for financial assistance, I agree to pay the outstanding balance in full, or set up payment arrangements. I agree and understand that any remaining balance not paid through financial assistance will be my responsibility. If account balances are not paid, I agree to pay the resulting collection charges, legal fees, and understand that access to Bethel Family Clinic services may be restricted. I understand that the financial assistance will expire one year or twelve (12) months on or before the date indicated below and I will be required to reapply. If there is a change in income, I will submit a new Sliding Fee Discount Program Application. You will receive a letter in the mail stating eligibility.

Signature: _____

Date: _____

-----*To be completed by BFC staff only*-----

Patient Has Qualified for the Following Discount					
<input type="checkbox"/> Does Not Qualify	<input type="checkbox"/> Slide A	<input type="checkbox"/> Slide B	<input type="checkbox"/> Slide C	<input type="checkbox"/> Slide D	<input type="checkbox"/> No Proof of Income

Financial Assistance Approved Until (Date): _____

Thank you for choosing Bethel Family Clinic as your healthcare provider. Based on the category indicated on the face of this document, please see below for discount detail. If you have any questions regarding your discount please contact Bethel Family Clinic at 907-543-3773 and request to speak with someone about the Sliding Fee Discount Program.

What Do I Owe?				
	FPG	Medical	Dental	Behavioral Health
A	0-100%	\$20	\$40	\$0
B	101-150%	\$40	\$80	\$5
C	151-175%	\$80	\$120	\$10
D	176-200%	\$120	\$160	\$15

NO PROOF OF INCOME WORKSHEET

BETHEL FAMILY CLINIC

Patient Status <i>Check One</i>					
	New Patient				
	Established Patient				
		Date:		MR#:	
Name:					
Date of Birth:		Social Security Number:			
Phone:		Marital Status: <i>Check One</i>		<input type="checkbox"/> Single	<input type="checkbox"/> Divorced
				<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
Have you applied for Medicare, Medicaid, Primary Care Network (PCN), or Children's Health Insurance Program (CHIP)? <i>(Check One)</i>					<input type="checkbox"/> Yes
					<input type="checkbox"/> No
Who provides financial support for you?					
Name:					
Relationship:					
Address:					
Phone Number:					

Patient Signature: _____

Date: _____

The following should be filled out by the person providing financial support

Patient fees are based on the type of service provided and the patient's income and household size. Our patient has listed you as the person who is financially supporting them. Please answer the following questions:

How long has the patient been living with you?	<i>Years</i>		<i>Months</i>	
How much financial support did you provide last month? (i.e., rent, utilities, food, etc.)				\$
Provide a brief description of the situation:				

Patient Supporter Signature: _____

Date: _____

Bethel Family Clinic

SLIDING FEE DISCOUNT PROGRAM SURVEY

Bethel Family Clinic (BFC) offers discounted services to patients who participate in the **Sliding Fee Discount Program (SFDP)**. To be eligible, you must live on a household income at or below 200% of Federal Poverty Guidelines (FPG). To determine if you live at or below this threshold,

your family size and annual income are aligned with poverty guidelines published by the US Department of Health & Human Services. After your proof of income is verified, BFC assigns you a

discount category letter, ranging from A-D. The discount category you land in, relative to your income and family size, determines how much of a discount you receive on services and what charge you are responsible to pay after your visit.

In order to assess the Sliding Fee Discount program’s effectiveness in reducing barriers to care for participants such as yourself, BFC has developed this survey. Please take a moment to answer a few questions regarding the program, to help BFC better understand where improvements can be made. Below is the 2020 Sliding Fee Discount Schedule. Note the services: M – Medical; D – Dental; BH – Behavioral Health.

ANNUAL INCOME											
Slide		A		B		C		D		E	
FPG		0-100%		101-150%		151-175%		176-200%		Over 200%	
Service	M	\$20		\$40		\$80		\$120		No Discount	
	D	\$40		\$80		\$120		\$160			
	BH	\$0		\$5		\$10		\$15			
Household Members	1	\$ -	\$ 16,090	\$ 16,091	\$ 24,135	\$ 24,136	\$ 28,158	\$ 28,159	\$ 32,180	\$ 32,181	& Up
	2	\$ -	\$ 21,770	\$ 21,771	\$ 32,655	\$ 32,656	\$ 38,098	\$ 38,099	\$ 43,540	\$ 43,541	& Up
	3	\$ -	\$ 27,450	\$ 27,451	\$ 41,175	\$ 41,176	\$ 48,038	\$ 48,039	\$ 54,900	\$ 54,901	& Up
	4	\$ -	\$ 33,130	\$ 33,131	\$ 49,695	\$ 49,696	\$ 57,978	\$ 57,979	\$ 66,260	\$ 66,261	& Up
	5	\$ -	\$ 38,810	\$ 38,811	\$ 58,215	\$ 58,216	\$ 67,918	\$ 67,919	\$ 77,620	\$ 77,621	& Up
	6	\$ -	\$ 44,490	\$ 44,491	\$ 66,735	\$ 66,736	\$ 77,858	\$ 77,859	\$ 88,980	\$ 88,981	& Up
	7	\$ -	\$ 50,170	\$ 50,171	\$ 72,255	\$ 72,256	\$ 87,978	\$ 87,979	\$ 100,340	\$ 100,341	& Up
	8	\$ -	\$ 55,850	\$ 55,851	\$ 83,775	\$ 83,776	\$ 97,738	\$ 97,739	\$ 111,700	\$ 111,701	& Up

Note: For families/households with more than 8 persons, add \$5,680 for each additional person.

For Office Use Only	
You belong to Sliding Fee Discount Category	

Example: If you belong to Discount Category A, you are responsible only to pay the nominal charge (\$20 for medical services, \$40 for dental services, or \$0 for behavioral health services). This will be your *only* financial obligation and the remainder of your bill will be discounted. If you belong to Discount Category C, you are required to pay a flat charge (\$80 for medical services, \$120 for dental services, or \$10 for behavioral health services). Again, this will be your *only* financial obligation and the remainder of your bill will be discounted.

1. How did you learn about the Sliding Fee Discount Program?

- Discussing Payment with Front Desk Staff
- Discussing My Bill Over the Phone
- My Provider
- On BFC's Website
- A Brochure at the Clinic
- A Poster at the Clinic
- From a Friend or Family Member who is a Patient at BFC
- Other: _____

2. How easy or difficult was it to understand your eligibility to participate in the program?

- Very Easy
- Somewhat Easy
- Difficult
- Very Difficult

3. How easy or difficult was it to understand how to enroll in the program?

- Very Easy
- Somewhat Easy
- Difficult
- Very Difficult

4. How easy or difficult was it to understand the program enrollment forms?

- Very Easy
- Somewhat Easy
- Difficult
- Very Difficult

5. How easy or difficult was it to understand the sliding fee discount schedule (the chart on the previous page)?

- Very Easy
- Somewhat Easy
- Difficult
- Very Difficult

6. How easy or difficult was it for you to obtain proof of income required to process your application?

- Very Easy
- Somewhat Easy
- Difficult
- Very Difficult

7. Did staff make themselves available to discuss any questions you had?

- Yes
- No
- NA – I did not have any questions

8. Were staff knowledgeable and direct in answering your questions?

- Yes
- No
- NA – I did not have any questions

9. If you speak a language other than English, was staff able to translate the program materials to your language and guide you through the process of eligibility and enrollment in the program?

- Yes
- Yes, but with difficulty and I still do not fully understand
- No

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10. Please use this space to communicate any additional concerns, comments, or questions you may have that will help Bethel Family Clinic strengthen program policies and procedures to the benefit of program participants such as yourself.

THANK YOU for your participation.