SLIDING FEE DISCOUNT PROGRAM APPLICATION

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 car, 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	**$**

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 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: __________________

NO PROOF OF INCOME WORKSHEET

Date: ____________________

Patient Status: New Patient Established Patient MRN # ___________________

Name: ____

Date of Birth: ____________________ Social Security Number: _______________________

Phone: __________________________ Marital Status: Single Divorced Married Widowed

Have you applied for Medicare, Medicaid, Primary Care Network (PCN), or Childrens Health Insurance Program (CHIP)?

Yes 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

How long has the patient been living with you? Years Months

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: ______________________

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 the 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 2022 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	$ -	$16,990	$16,991	$25,485	$25,486	$29,733	$29,734	$33,980	$33,981	& Up
	2	$ -	$22,890	$22,891	$34,335	$34,336	$40,059	$40,059	$45,780	$45,781	& Up
	3	$ -	$28,790	$28,791	$43,185	$43,186	$50,383	$50,384	$57,580	$57,581	& Up
	4	$ -	$34,690	$34,691	$52,035	$52,036	$60,708	$60,709	$69,380	$69,381	& Up
	5	$ -	$40,590	$40,591	$60,885	$60,886	$71,033	$71,034	$81,180	$81,181	& Up
	6	$ -	$46,490	$46,491	$69,735	$69,736	$81,358	$81,359	$92,980	$92,981	& Up
	7	$ -	$52,390	$52,391	$78,585	$78,586	$91,683	$91,684	$104,780	$104,780	& Up
	8	$ -	$58,290	$58,291	$87,435	$87,436	$102,008	$102,009	$116,580	$116,581	& Up

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 below 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
   - ☐ Diffcult
   - ☐ Very Difficult

3. How easy or difficult was it to understand your eligibility to participate in the program?
   - ☐ Very Easy
   - ☐ Somewhat Easy
   - ☐ Diffcult
   - ☐ Very Difficult

4. How easy or difficult was it to understand the program enrollment forms?
   - ☐ Very Easy
   - ☐ Somewhat Easy
   - ☐ Diffcult
   - ☐ 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
   - ☐ Diffcult
   - ☐ Very Difficult

6. How easy or difficult was it for you to obtain proof of income required to process your applications?
   - ☐ Very Easy
   - ☐ Somewhat Easy
   - ☐ Diffcult
   - ☐ 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
   ☐ No
   ☐ NA – I did not have any questions

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.**

<u>THANK YOU</u> *for your participation*

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

Patient has qualified for the Following Discount					
☐ Does Not Qualify	☐ Slide A	☐ Slide B	☐ Slide C	☐ Slide D	☐ 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.

Employee Signature: ____ Date Received: ____________________

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