Kids Health Alliance Discounted/Sliding Fee Policy

Policy

It is the policy of Kids Health Alliance to provide essential medical services to all patients, regardless of the patient's ability to pay. Discounts are offered to those who qualify based upon family/household size and annual income. A sliding fee schedule is used to calculate the basic discount and is updated each year using the Federal Poverty Guidelines. Once the application is approved, the discount will be honored for six months, after which the patient must reapply.

Discount Application Process

To apply for our Sliding Fee Schedule, the patient must provide necessary documentation along with a completed application. The required documentation includes proof of:

- Home Address
- Household Income

The discount will apply to all services received at this clinic, but not those services purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 6 months, or if your financial situation changes.

Nominal Fee: Patients receiving a full discount will be assessed a $10 nominal fee per visit. However, patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

Refusal to Pay: If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the patient does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, Kids Health Alliance can explore options not limited, but including offering the patient a payment plan, waiving of charges, or referring the patient to collections. In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by Kids Health Alliance Management.

Collections: Patients who refuse to adhere to a payment plan and do not report any special circumstances that may lead to waiving of charges may be sent to Collections on a case-by-case

basis after 3 written statements have been sent from our office and we have been unsuccessful in reaching the patient and collecting the payment by phone.

Application Process: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence.

Your yearly **income tax return**, a copy of your **W-2 form**, last month's **paycheck stubs**, copies of your **social security checks**, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

> **a) Income includes:** earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.
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> **b) Family is defined as:** a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

IF YOU DO NOT HAVE THE NECESSARY DOCUMENTATION AT TIME OF VISIT, IT IS YOUR RESPONSIBILITY TO BRING IT TO US SO THAT WE HAVE IT ON FILE, OR YOU WILL HAVE AN ACCOUNT BALANCE AND BE SENT A STATEMENT FOR THE FULL SELF PAY FEE.

Discounted/Sliding Fee Application

Patient Information			Today's Date: / /		
First Name:	Middle:	Last:	Date of Birth: / /		
Home Address:		City:	State:	Zip:	
Mailing Address:		City:	State:	Zip:	
Email:		Cell Phone #:	Home Phone #:		

Household Members	Household Income	
Name	**Annual**	**Monthly**

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program. I further agree to inform Kids Health Alliance if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Kids Health Alliance. I hereby acknowledge that I read the foregoing disclosure and understand it.

Name: ____________________________________ Date:______________________

Signature: _________________________________

Office Use Only

Patient Name: Discount:

Date of service: Approved By: