# Sliding Fee Program

SDHS, Inc. offers a Sliding Fee Discount to patients. Patients who cannot afford to pay for medical or dental care in full may qualify for a discount on the services provided to them at SDHS, Inc. medical, mental health and dental sites.

## What Services Are Offered?

- Medical
- Mental Health
- X-Ray & Labs
- Dental

## What is Required to Apply?

Complete the enclosed application packet. Provide proof of household income or financial assistance. Household is defined as the applicant plus spouse plus their legal tax dependents.

**Please use the following checklist for each applicable section**

**Employed Patients (must provide at least 1 of the following)**

- ☐ Pay Stubs – last 3 consecutive pay stubs of everyone working in the household
- ☐ Current W2
- ☐ Self Employed: Profit & Loss statement from tax return
- ☐ Self Employed (but do not have a tax statement) please use SDHS Self-Employment Statement of Income form enclosed
- ☐ Statement employer (form enclosed) showing your GROSS earnings for the previous month.

**Child Support (must provide at least 1 of the following)**

- ☐ Court Order
- ☐ Division of Child Support Awards Letter

**Social Security (must provide at least 1 of the following)**

- ☐ Awards letter from Social Security Administration
- ☐ Copy of benefits check

**Food Stamps (must provide at least 1 of the following)**

- ☐ Awards letter from Department of Social Services
- ☐ Denial letter from Department of Social Services

**Inheritance/Court Ordered Payments/Spousal Support (must provide at least 1 of the following)**

- ☐ Court Order

**No Verifiable Income (must provide both of the following)**

- ☐ SDHS Zero Income-Self Declaration (form enclosed)
- ☐ SDHS Statement of Personal Assistance (form enclosed)

# Will I Qualify?

Eligibility for the Sliding Fee Program is based on the family size and GROSS income (before taxes). All applicants will be notified of their Slide application effective and expiration dates through a SDHS Awards Letter. It is your responsibility to provide all the required information when returning your application. An incomplete application will **NOT** be accepted nor processed.

# How Often Do I Need to Apply?

Patients will need to apply for the Sliding Fee Program at least once every year. The discounts will typically last 3,6, or 12 months depending on the patient's unique financial situation. Patients renewing slide eligibility will need to complete a new slide application packet and submit current proof of income before their discounts expire. If the discount expires, the patient will be responsible for paying the full charges until a new application is processed and approved.

# Financial Responsibility

SDHS requests that payment for services at the time of service. If full payment cannot be made, a payment plan must be executed at the time of the visit. Non-payment of sliding fee charges/labs/percentage after three (3) visits the patient will no longer be eligible for their current slide. The patient's financial responsibility will be self-pay. When the patient's account balance is current, they can reapply for the sliding fee program. No discount will be awarded to individuals or families with an annual income greater than 200% of FPG. Any change in household **or** financial status must be reported as soon as possible, and a new application must be completed.

**By signing below, I acknowledge that I have read and understood the above guidelines and intend to follow them to the best of my ability.**

______________________________________

Signature of Applicant Date

# Sliding Fee Program Application

## Applicant Information

Office Location: ☐ Lunenburg ☐ Amelia ☐ Dinwiddie ☐ Emporia ☐ Family Dentistry

Name of Responsible Party ______________________________ Date of Birth ________________

Address __________________________________________ SSN ______________________

City ________________ State _________ Zip __________

Home Phone ______________ Cell Phone ________________ Work Phone ________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

Employer ____________________________ Employer's Address __________________________

## Household Members

Household = Spouse + Tax Dependents

| Name (First, Last) | Relationship | Date of Birth | Social Security # |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Household Income

Household = Spouse + Tax Dependents

| Income | You (the applicant) | Spouse | Other Household Members (over 18) |
|---|---|---|---|
| Name/Address of Employer | | | |
| Gross Wages, Salaries & Tips (week, bi-weekly, or monthly circle one) | $ | $ | $ |
| Welfare/Food Stamps | $ | $ | $ |
| Social Security | | | |
| Unemployment Benefit Date of Layoff: _________ | | | |
| Child Support | | | |
| Worker's Compensation | | | |
| Other-Specify: __________ | | | |

## Required Proof of Income

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## Patient Agreement

I certify that all statements contained herein are true and correct and subject to verification. I authorize the release of employment records and other financial information to an agent of SDHS for sliding fee determination purposes only. I understand that I must report any and all income changes as they occur and if I do not, then I forfeit my rights to be on the Sliding Fee Discount. Application must be returned in 10 days from date listed below.

_______________________________ _______________________________

Signature Date

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FOR OFFICE USE ONLY

Approval Signature: _______________________ Date: _______________________

Sliding Fee Rate: _______________ Account #: _____________ Renewal Date: _______________

# Sliding Fee Program

## Statement of Income From Employer

Have your Employer complete this form if no paystubs or tax return available

To Whom It May Concern:

Your employee, (applicant's name) ________________________________________, is applying for our Sliding Fee Program (to help with medical expenses). In order to process his/her application, we must have proof of their last/previous month's gross income.

Therefore, please advise us of how much he/she makes per hour, and approximately how many hours he/she works per week.

$_______________ per hour x _____________ hours per week (approximately)

OR, IF THE ABOVE IS NOT PRACTICAL FOR YOUR TYPE OF BUSINESS, PLEASE COMPLETE THE FOLLOWING:

GROSS EARNINGS for the last/previous month:

Month: ___________________ 20 _____ $_____________________

Name of Employer: _________________________________________________________________

Direct Supervisor: _________________________________________________________________

Address: _________________________________________________________________________

Phone: __________________________________________________________________________

Employer's Signature ____________________________________________ Date __________________

# Sliding Fee Program

## ZERO Income – Self Declaration of Income

Complete this form only if you have no income to report

I, ________________________________, certify that I have NO source of income.

Name of last employer _______________________________ Date of last employment ____________

Household/Family Size: _________

I am currently:

- ☐ Unemployed – looking for employment. Not receiving unemployment benefits.
- ☐ Seeking Disability. If so, when did you last apply? _______________ Have you been denied? _____
- ☐ Other _______________________________________

I certify that all statements contained herein are true/correct, and subject to investigation. I also authorize the release of employment records and other financial information to an agent of Southern Dominion Health System, Inc. for sliding fee determination purposes only.

Signed: ________________________________ Date: _______________________________

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Instructions: If you have NO (or limited) income and are receiving help from friends/family, the following must be completed, signed and dated by your benefactors. No financial obligation will be placed on this individual, this is for office use only to verify the situation of the applicant.

## Statement of Personal Assistance

I, ________________________________________, assist _____________________________ (patient) by providing basic living needs listed below:

- ☐ Food
- ☐ Shelter
- ☐ Utilities
- ☐ Money: Amount $ ______________

By providing my information below, I do not take responsibility for said patients' financial obligations. I can be reached to verify this information at:

My Name: ________________________ Phone Number: _________________

Signature: ________________________ Date: _________________________

# Sliding Fee Program

## Self-Employment Statement of Income

Complete this form only if you are self-employed and do not file taxes

Business Name: ______________________________________________

Business Owner(s): ______________________________________________

Business Address: ______________________________________________

______________________________________________

Business Phone Number: ______________________________________________

Brief Description of Business: ______________________________________________

______________________________________________

GROSS Earnings (For the business owner = what you paid yourself, not the business gross)

Need Past 3 Months. Complete Below.

| Month______ | Year 20____ | Month ______ | Year 20_____ | Month ______ | Year 20_____ |
|---|---|---|---|---|---|
| Week 1 | $ | Week 1 | $ | Week 1 | $ |
| Week 2 | $ | Week 2 | $ | Week 2 | $ |
| Week 3 | $ | Week 3 | $ | Week 3 | $ |
| Week 4 | $ | Week 4 | $ | Week 4 | $ |
| Week 5 | $ | Week 5 | $ | Week 5 | $ |
| Monthly Total | $ | Monthly Total | $ | Monthly Total | $ |

______________________________________________ ______________________________

Signature of Business Owner Date