SOUTHEAST PEDIATRICS P.C. APPLICATION SLIDING FEE DISCOUNT

Name:_____ Date of Birth_____

Address:_____

Street City State Zip Code

Phone:_____ Medicare: Y/N Medicaid: Y/N Insurance: Y/N

Married: Y/N Total # of household members:_____(List all below)

Name	Date of Birth	Relationship	Name	Date of Birth	Relationship
Name	Date of Birth	Relationship	Name	Date of Birth	Relationship
Name	Date of Birth	Relationship	Name	Date of Birth	Relationship

---

Please include information for ALL employed individuals in the household. (Self, Spouse, Children, Other) Please attach additional page(s) if necessary.

Name of Employer:_____ Work Phone:_____

Address:_____ Monthly Gross Pay:_____

***Monthly____(once) /Bi-Weekly____(every two weeks)/ Twice Monthly____(two times a month)/ Weekly___

Name of Employer:_____ Work Phone:_____

Address:_____ Monthly Gross Pay:_____

***Monthly____(once) Bi-Weekly____(every two weeks) /Twice Monthly____(two times a month)/ Weekly____

Other Income (includes social security, unemployment, pensions, alimony, other aid, etc.)

Source:_____ Amount:_____

Source:_____ Amount:_____

By signing this application, I understand and agree to the following:

- **I must provide Southeast Pediatrics P.C. with verification of all household income spanning the most recent 30 days. (Discount may not be approved until all household income verification is received. Pay stubs, tax returns, etc.)**
- **Employers named above may be contacted to verify income information**
- **I must notify Southeast Pediatrics P.C. immediately of any change in my household's financial status**
- **Some procedures or services may not be covered by this discount**

I swear to affirm that the information given on this application is true and correct to the best of my knowledge and belief.

Applicant's Signature:_____Today's Date:_____

OFFICE USE ONLY: Total Family Annual Income:_____ Authorized by:_____

Discount Assigned:_____Level _____Checked by:_____

General Policy:

Southeast Pediatrics P.C. offers a Sliding Fee Discount to all patients who are uninsured or under-insured. Charges will be discounted based on the patient's ability to pay. This sliding Fee Discount Scale is based on the most current issuance of the United States Department of Health and Human Services Federal Poverty Guidelines. These numbers are issued annually and our Sliding Fee Discount Scale is updated accordingly.
You do **not** need to be uninsured to receive a Sliding Fee Discount. If you are insured and you meet eligibility standards, the sliding fee discount will be applied after all insurance payments are received and posted to your account.

Eligibility:

Eligibility for the Sliding Fee Discount is determined by annual household income and family or household size.

To Apply:

Please ask a **Southeast Pediatrics P.C.,** Patient Service Representative for a Sliding Fee Discount Application.
Complete the application in full.
Attach the most recent 30 day proof of income.
Return to a **Southeast Pediatrics P.C.**, Patient Service Representative.

Completing an Application:

The following information is required on all Sliding Fee Discount Applications:
Applicant Name (First & Last)
Applicant Date of Birth
Address
Current Phone Number
Total # of Household Members
Insurance/Medicare/Medicaid (Medical Card)/Commercial
Household Members Information
Employer Information for applicant/head of household/spouse (if applicable)
Proof of Income
Other sources of income if applicable

NOTE: Incomplete applications or those missing proof of income will not be accepted.

Acceptable Proof of Income:

Proof of income covering the most recent 30 days must be included with the Sliding Fee Discount Application.

Most current months pay stubs (30 days) including Tips
Letter from Employer on company letterhead
Social Security Letter of Benefit
Unemployment Letter of Benefit
Retirement Benefits
Income Tax Return
1099 Form
Military Benefits
Veterans Benefits
Alimony
Other
W-2 Form

Sliding Fee Discount Patient Information

No Income:

Applicants who indicate they and other members of their household receive no income must complete the **Southeast Pediatrics** P.C. Self Declaration of No Income Form and include it with the completed Sliding Fee Discount Application.

Applicants that indicate that they and other members of their household are living with other friends or family, must provide a letter written by the person in whose home they are staying, as to the accuracy of such information.

The letter should ALSO include the friend or family members:
Name
Address
Telephone Number
Personal Signature

Discounts Assigned:

Upon approval of a Sliding Fee Discount the following discounts will be applied to all applicable Southeast **Pediatrics P.C**. visits.

- See attached Appendix A

In the event that the balance remaining after all insurance payments have been received and posted is less than the categorized patient responsibility payment amount; no further discount will be applied to that date of service.

Disclaimer:

Once the Sliding Fee Discount Application has been processed and a discount has been approved, the discount will remain in effect for one (1) year. Upon expiration the applicant must complete a new application and provide new or most current proof of income. This is required even if nothing on the expired discount period has changed. It is unacceptable to write "Same as previous year" or "Unchanged" on a new Sliding Fee Discount Application.

Non Covered Services and Supplies:

The following services and/or supplies are NOT covered by a sliding fee discount program.

Medical Services	Medical Supplies	Dental Services	Dental Supplies
Drug Testing (per Controlled Substance Policy)	Pessaries	Bridges Occlusal Adjustments	Whitening Occlusal Guards(bite/mouth guards)

Acquisition Fees:

- Supplies: IUD's, Nexplanon – patient pays Acquisition cost
- Services: Injection, Immunizations/vaccines – patient pays Acquisition cost

Self Declaration of No Income Form

I, (applicant)_____ , do hereby declare under penalty of perjury that I am currently unemployed and not receiving income from any source, including; unemployment, disability, SSI, pension, other household or family income.

I declare that the information stated above is true to the best of my knowledge and I understand that any misrepresentation may be grounds for termination of my or family/household sliding fee discount.

I agree that if my income status changes in any way, I will notify Rural Health, Inc. immediately at which time I will be required to complete a new sliding fee discount application and provide evidence of my household income.

_____ _____

Applicant Signature Date

Southeast Pediatrics P.C. Personnel

Reviewed by:_____

Date:_____