Policy Name: Sliding Fee Discount Program	**Originating Department** **Finance**
Laws, Regulations or Standards Associated with this Policy: Health Center Program Compliance Manual, Federal Poverty Level Guidelines	
Related Policies; Finance 957 Waiver of Charges; Finance 975 Payment Plan Policy	
Related Attachments: Attachment A: Procedures Attachment B: Sliding Fee Discount Scales Attachment C: Sliding Fee Discount Program Application Attachment D: Payment Plan Letter Attachment E: Low-Income Statement Attachment F: One Day Request for Sliding Fee Discount Program Consideration Attachment G: Sliding Fee Additional Services Fee Schedule	
Policy Type: ☐ **New** ☒ **Revision** ☐ **Replacement (specify):**	

POLICY:

NHCLV provides a discount on all services under the approved scope of services for patients qualifying for the Sliding Fee Discount Program based on income and family size and no other factors.

Patients who have income at or below 200% of the Federal Poverty Level (FPL) are qualified to receive a discount on services upon completion and approval of a Sliding Fee Discount Program application. Patients with income at or below 100% of the FPL qualify for a full discount, whereby only a nominal fee is requested. The Sliding Fee Discount Program, through use of the FPL, provides discounts on a sliding fee scale basis for any patient(s) between 101% and 200% of FPL. Refer to the Sliding Fee Discount Scale for details on the nominal fee and sliding fee scale discount rates.

The Sliding Fee Discount Program application requires a patient to provide information on members in the household (family size) and the income of members in the household, along with proof of income to document four weeks (approximately one month) of income for each member in the household with income.

The Sliding Fee Discount Program is established to ensure patients are able to access services provided by NHCLV, with discounted fees set at a reasonable amount to assure no patient is denied care due to an inability to pay. Patients will be informed of the Sliding Fee Discount Program through posted signage at all service locations, patient brochures, NHCLV's website and through NHCLV staff.

PURPOSE: To set forth guidelines for the Sliding Fee Scale Discount Program, including eligibility, application, sliding fee scale, and nominal fees.

DEFINITION OF TERMS:

Sliding Fee/Self-pay Patient: A patient who has been approved for the Sliding Fee Scale Discount Program and as such has documented income at or below 200% of the FPL. A patient may or may not have medical insurance.

Self-pay Patients 100%: A patient with incomes above 200% of FPL is a self-pay patient who does not qualify for a sliding fee discount on primary care services provided by NHCLV. Self-pay patients are responsible for 100% full charges for services received. These patients may or may not have medical insurance.

Covered Patients: A patient with insurance coverage through either a private insurance carrier or public health plan program (i.e. Medicare, Medicaid, SCHIP, and ACA Marketplace). Covered patients, whose plans require the patient to pay deductibles, co-payments, and/or co-insurance

amounts, are required to make these payments for services provided by NHCLV. Patients that have insurance and qualify for the sliding fee discount will pay no more for their deductible or co-insurance than they would have paid under the appropriate sliding fee discount, unless prohibited by their insurance coverage.

Dependent: All individuals as defined by the IRS guidelines.

Household: Household includes all the persons who occupy a housing unit including all dependents.

Income: Gross income reported for federal income tax purposes. This includes wages, tips, social security disability, veteran payments, alimony, child support, military, unemployment, and public aid. Individuals whose income is to be included is head of household, spouse/significant other/partner, and dependents over 18 years of age.

Proof of Income: Paycheck stubs; signed letter from the employer stating hours worked per week or biweekly and pay per hour; for unearned income---proof of child support, social security statements or unemployment check stubs; or if no household income---a document denying medical assistance.

Sliding Fee/Self-pay Discount: A discount based on the current Federal Poverty Level (FPL) Guidelines. Patients at or below 100% of FPL receive a full discount with only a nominal fee requested for services provided by NHCLV (SFS Category A). The Nominal Fee is not based on the actual/true cost of the service provided. No patient is denied care due to inability to pay. Patients with incomes between 101% and 200% of FPL will receive a discount corresponding to each income level on the Sliding Fee Discount Scale (SFS Categories B through D):

Slide Fee Scale	**Medical or Behavioral Visit Fee**	**Dental Visit Fee**
SFS-A (below 100% FPL):	$20	$25
SFS-B (101%- 125% FPL):	$35	$40
SFS-C (126%-150% FPL):	$45	$50
SFS-D (151%-200% FPL):	$55	$60
100% Patient Responsibility	Full Charge	Full Charge

- Nurse Visit fee for a visit including one immunization/injection or administration of PPD: $10
- Nurse Visit fee (not including birth control) for a visit including more than one service (i.e., immunization and injection; Two or more immunizations, immunization and PPD administration): $15
- Non-LARC Birth Control Nurse Visit 3-month Refill: Slide A ($0); Slide B ($15); Slide C ($25); Slide C ($25); Slide D ($35)
- BHI-COE only services: Slide A (no charge); Slide B ($5); Slide C ($10); Slide D ($15)

To ensure that the nominal fee is not considered a barrier to care, NHCLV will attempt to survey patients on a periodic basis, but at a minimum will survey all patient Board members annually.

Exception Process: In the absence of the Front Office Coordinator or Manager, Billing Team lead may support this function.

Monitoring: The Chief Financial Officer or designee will monitor on a regular basis. Board ofDirectors will monitor as part of fiscal oversight.

Review & Approval: LAST REVIEW OR REVISION DATE:

04/25/2022 Board of Directors – Changes effective 05/01/2022
06/21/2021 Board of Directors – Changes effective 07/01/2021
04/19/2021Board of Directors
01/18/21 Board of Directors
07/20/20 Board of Directors
02/17/20 Board of Directors
07/19/19 Board of Directors
01/05/17 Board of Directors
01/10/16 Board of Directors
06/08/15 Board of Directors

ISSUE DATE: 01/13/2014

EFFECTIVE DATE: 01/13/2014

ATTACHMENT A: PROCEDURES

1. The Front Desk Staff will identify self-pay patients during scheduling and registration and identify patients who are eligible for the sliding fee/self-pay discount based on completion ofthe Sliding Fee Discount Program application and meeting criteria of program.
2. The Front Desk Staff will determine which application to give the patient based on the patient's documentation at time of service. If the patient has income verification, the Patient will fill out the Sliding Fee Scale Discount Program Application. If the patient does not have income verification, the patient will fill out the One Day Visit Application.
3. If the patient declines to fill out either the Sliding Fee Scale Discount Program Application or the One Day Visit Application, patient will be informed by staff person that any services provided that day will be at full office charges.
4. On the initial patient visit, staff will apply the sliding fee/self-pay discount for qualifying patients based on the patient's One Day Visit Application of the number of members in the household (family size) and household income for this initial visit. However, future discounts are contingent on the patient fulfilling the documentation requirements for the Sliding Fee Scale Discount Program application, including copies of four weeks (approximately one month) of income for each member in the household with income. Attempts to collect needed information by NHCLV staff will be recorded in PMS/EMR (including but not limited to phone conversations, mailed communication). Until documentation is received and before the next appointment is scheduled the patient account is set to full-pay (and process re-starts upon patient request). There is no period of allowance for documents to be received by patient. In other words, no 'buffer' between date of first appointment and next appointment where the initial One Day Visit Application counts for more than just the one date of service without appropriate documentation. **Each date of service without appropriate documentation requires its own separate request for consideration if income and household size documents are unavailable for verification.**
5. The Slide Designation for the patient must be set to expire within one day (i.e., if date of service is July 1, 2021, then expiration is July 2, 2021). This allows the billing time adequate time to handle billing for date of service and gives the patient a full 24 hours of approval.
6. If eligibility for other discounted programs is identified, the patient will be referred so their eligibility may be determined. NHCLV staff will be available for assistance if patient requestsassistance with process.
7. For patients reporting no recordable income due to living situations or other situations a "Limited Income Statement" may be completed by patient and serve as attestation that he/she isunable to provide income related documents and the reasons why. This letter shall serve as proof of income as relates to this policy and should be completed at time of initial applicationas needed. This form is ONLY to be used for patients who cannot and will not be able to provide ANY proof of income or be eligible for public or private insurance coverage.
8. Once a patient completes the Sliding Fee Discount Scale Program application, including required documentation, and is approved for the discount program, the discount will remainin effect for one year, at which time the patient must update his/her application. At any timeduring the discount approval year, if the patient's household size or income status changes, anew Sliding Fee Discount Program application must be completed and

approved to change the discount rate as appropriate.

9. Once approved, staff will apply the discount for Sliding fee/self-pay patients, at the time ofservice.

10. Sliding fee/self-pay patients are required to pay the discounted patient share at the time of service. Staff will review the charges for services rendered, apply the appropriate discount,and determine the balance due by the patient. **Staff will collect the amount due from the sliding fee/self-pay patient on the day of service.**

11. After staff have reviewed documentation and approved the patient for the Sliding Fee ScaleDiscount Program, staff will initiate the self-pay discount category in the practice management/ electronic health record system and place alert in system that indicates SFS level.

12. If the patient is not able to make payment at the time of the initial visit, the Patient Service Representative (PSR) will provide the patient with payment plan options. *See Finance-975 Payment Plan policy*.

13. If insurance information is found or supplied by the patient after the self-pay discounts havebeen applied, the discount will be reversed and the total charge forwarded to the billing specialist for further collection activity. Any payments received by the patient for the day of service that is now covered by insurance will be credited to the patient's account in the practice management system or refunded to patient.

14. The payment will be collected from the patient and posted in the patient's practicemanagement/electronic health record system.

15. Billing statements will be issued to all patients on monthly basis, including patients qualifying for the Sliding Fee Scale Discount Program. Staff will also provide a billing statement to patients with outstanding balances at check-in to remind the patient of the balance due, collect the balance due, and/or establish payment arrangement with the patients. The billing statement will include a message of previous dates-of- service, chargeamount(s), and timeline of when outstanding balance is due.

16. See *Finance-957 Waiver of Charges Policy* for details on circumstances qualifying for such waiver.

17. The *Finance-955 Sliding Fee Discount Program Policy* will be updated annually to address anychanges to the Federal Poverty Level Guidelines.

18. The Board will review the *SFSDP Policy* at least every two years to ensure that it is notcreating a barrier to care.

19. NHCLV will make every effort to work with referral partners to ensure that patients haveaccess to a discounted program that is similar to this SFDS.

Neighborhood Health Centers of the Lehigh Valley

FB-955 Attachment B - NHCLV Sliding Fee
Review Date: 04/25/2022

Sliding Discount Fee Program Scales for Medical, Behavioral Health, and BHI-COE Service Visits

	SFS Level A (0% – 100% FPL*)	SFS Level B (101%- 125% FPL*)	SFS Level C (126% – 150% FPL*)	SFS Level D (151% - 200%FPL*)	Income Over 200% FPL*
	• Medical or Behavioral Health visit= $20 • Women's Health Visit inclusive= $25 • Behavioral Health Visit as 2nd Service on Same Day= $10 • BHI-COE as single Service= $0	• Medical or Behavioral Health visit= $35 • Women's Health Visit inclusive= $50 • Behavioral Health Visit as 2nd Service on Same Day= $15 • BHI-COE as single Service= $5	• Medical or Behavioral Health visit= $45 • Women's Health Visit inclusive= $65 • Behavioral Health Visit as 2nd Service on Same Day= $20 • BHI-COE as single Service= $10	• Medical or Behavioral Health visit= $55 • Women's Health Visit inclusive= $80 • Behavioral Health Visit as 2nd Service on Same Day= $25 • BHI-COE as single Service= $15	*Patients making over 200% of the FPL will be billed the full price of the visit at time of check-in.*

Family Size	Income Less Than		Income Less Than		Income Less Than		Income Less Than		
	Monthly	*Annually*	*Monthly*	*Annually*	*Monthly*	*Annually*	*Monthly*	*Annually*	
1	$1,132	$13,590	$1,415	$16,988	$1,698	$20,385	$2,265	$27,180	Nurse Visits: Level One: $10 Level Two: $15*
2	$1,525	$18,310	$1,907	$22,888	$2,288	$27,465	$3,051	$36,620	
3	$1,919	$23,030	$2,399	$28,788	$2,878	$34,545	$3,838	$46,060	
4	$2,312	$27,750	$2,890	$34,688	$3,468	$41,625	$4,625	$55,500	
5	$2,705	$32,470	$3,382	$40,588	$4,058	$48,705	$5,411	$64,940	*This is not for income over 200%
6	$3,099	$37,190	$3,874	$46,488	$4,648	$55,785	$6,198	$74,380	
7	$3,492	$41,910	$4,365	$52,388	$5,238	$62,865	$6,985	$83,820	
8	$3,885	$46,630	$4,857	$58,288	$5,828	$69,945	$7,771	$93,260	

Each family member add $4,720 Level A, $5,900 Level B, $7,080 Level C, $9,440 Level D

*Based on Federal Poverty Guidelines Jan 2022, Federal Register- www.federalregister.gov; https://aspe.hhs.gov/poverty-guidelines

Neighborhood Health Centers of the Lehigh Valley

FB-955 Attachment B - NHCLV Sliding Fee

Review Date: 04/25/2022

Programa de Descuento de Tarifas para visitas médicas, salud mental, y BHI-COE

Sliding Discount Fee (SDFS) Program for Medical, Behavioral Health, and BHI-COE Service Visits

	SFS Nivel A (0% – 100% FPL*)	SFS Nivel B (101%- 125% FPL*)	SFS Nivel C (126% – 150% FPL*)	SFS Nivel D (151% - 200%FPL*)	Ingresos mayor 200% FPL*
	· Visita médica o salud conductual = $20 · Visita de cuidado femenino= $25 · Visita de salud mental como segunda visita en el mismo día= $10 · Visita BHI-COE como servicio único = $0	· Visita médica o salud conductual = $35 · Visita de cuidado femenino= $50 · Visita de salud mental como segunda visita en el mismo día = $15 · Visita BHI-COE como servicio único = $5	· Visita médica o salud conductual = $45 · Visita de cuidado femenino= $65 · Visita de salud mental como segunda visita en el mismo día = $20 · Visita BHI-COE como servicio único = $10	· Visita médica o salud conductual = $55 · Visita de cuidado femenino= $80 · Visita de salud mental como segunda visita en el mismo día =$25 · Visita BHI-COE como servicio único = $15	*A los pacientes que obtengan más del 200% del FPL se les facturará el precio total de la visita al momento de registración*

Tamaño de la familia	Ingresos menores que		Ingresos menores que		Ingresos menores que		Ingresos menores que		
	Mensual	*Anual*	*Mensual*	*Anual*	*Mensual*	*Anual*	*Mensual*	*Anual*	
1	$1,132	$13,590	$1,415	$16,988	$1,698	$20,385	$2,265	$27,180	
2	$1,525	$18,310	$1,907	$22,888	$2,288	$27,465	$3,051	$36,620	
3	$1,919	$23,030	$2,399	$28,788	$2,878	$34,545	$3,838	$46,060	Nurse Visits: Nivel 1: $10 Nivel 2: $15*
4	$2,312	$27.750	$2,890	$34,688	$3,468	$41,625	$4,625	$55,500	
5	$2,705	$32,470	$3,382	$40,588	$4,058	$48,705	$5,411	$64,940	
6	$3,099	$37,190	$3,874	$46,488	$4,648	$55,785	$6,198	$74,380	*No es para los de > 200%FPL
7	$3,492	$41,910	$4,365	$52,388	$5,238	$62,865	$6,985	$83,820	
8	$3,885	$46,630	$4,857	$58,288	$5,828	$69,945	$7,771	$93,260	

Por cada miembro de familia adicional, añada: $4,720 Nivel A, $5,900 Nivel B, $7,080 Nivel C, $9,440 Nivel D

*Basado en Federal Poverty Guidelines Jan 2022 Federal Register- www.federalregister.gov; https://aspe.hhs.gov/poverty-guidelines

FB-955 Attachment B - NHCLV Sliding Fee
Review Date: 04/25/2022

NHCLV Dental Sliding Fee Scale (SFS) Program

	SFS Level A (0% – 100% FPL*)		SFS Level B (101%- 125% FPL*)		SFS Level C (126% – 150% FPL*)		SFS Level D (151% - 200%FPL*)		Income Over 200% FPL*
	$25 per Dental Visit		$40 per Dental Visit		$50 per Dental Visit		$60 per Dental Visit		*Patients making over 200% of the FPL will be billed the full price of the visit at time of check-in.*
Family Size	Income Less Than		Income Less Than		Income Less Than		Income Less Than		
	Monthly	*Annually*	*Monthly*	*Annually*	*Monthly*	*Annually*	*Monthly*	*Annually*	
1	$1,132	$13,590	$1,415	$16,988	$1,698	$20,385	$2,265	$27,180	
2	$1,525	$18,310	$1,907	$22,888	$2,288	$27,465	$3,051	$36,620	
3	$1,919	$23,030	$2,399	$28,788	$2,878	$34,545	$3,838	$46,060	
4	$2,312	$27.750	$2,890	$34,688	$3,468	$41,625	$4,625	$55,500	
5	$2,705	$32,470	$3,382	$40,588	$4,058	$48,705	$5,411	$64,940	
6	$3,099	$37,190	$3,874	$46,488	$4,648	$55,785	$6,198	$74,380	
7	$3,492	$41,910	$4,365	$52,388	$5,238	$62,865	$6,985	$83,820	
8	$3,885	$46,630	$4,857	$58,288	$5,828	$69,945	$7,771	$93,260	

Dental Preventative Services
- Exams
- X-rays
- Prophy
- Fluoride
- Sealants

Each family member add $4,720 Level A, $5,900 Level B, $7,080 Level C, $9,440 Level D

*Based on Federal Poverty Guidelines Jan 2022, Federal Register- www.federalregister.gov; https://aspe.hhs.gov/poverty-guidelines

Neighborhood Health Centers of the Lehigh Valley

NHCLV Dental Sliding Fee Scale (SFS) Program

	SFS Nivel A (0% – 100% FPL*)		SFS Nivel B (101%- 125% FPL*)		SFS Nivel C (126% – 150% FPL*)		SFS Nivel D (151% - 200%FPL*)		Income Over 200% FPL*
	$25 por visita dental		$40 por visita dental		$50 por visita dental		$60 por visita dental		*A los pacientes que obtengan más del 200% del FPL se les facturará el precio total de la visita al momento de registración*
Tamaño de la familia	Ingresos menores que		Ingresos menores que		Ingresos menores que		Ingresos menores que		
	Mensual	*Anual*	*Mensual*	*Anual*	*Mensual*	*Anual*	*Mensual*	*Anual*	
1	$1,132	$13,590	$1,415	$16,988	$1,698	$20,385	$2,265	$27,180	
2	$1,525	$18,310	$1,907	$22,888	$2,288	$27,465	$3,051	$36,620	
3	$1,919	$23,030	$2,399	$28,788	$2,878	$34,545	$3,838	$46,060	
4	$2,312	$27.750	$2,890	$34,688	$3,468	$41,625	$4,625	$55,500	
5	$2,705	$32,470	$3,382	$40,588	$4,058	$48,705	$5,411	$64,940	
6	$3,099	$37,190	$3,874	$46,488	$4,648	$55,785	$6,198	$74,380	
7	$3,492	$41,910	$4,365	$52,388	$5,238	$62,865	$6,985	$83,820	
8	$3,885	$46,630	$4,857	$58,288	$5,828	$69,945	$7,771	$93,260	

Servicios dentales preventivos
- Exámenes
- Radiografías
- Profilaxis
- Fluoruro
- Selladores

Por cada miembro de familia adicional, añada: $4,720 Nivel A, $5,900 Nivel B, $7,080 Nivel C, $9,440 Nivel D

*Basado en Federal Poverty Guidelines Jan 2021, Federal Register- www.federalregister.gov; https://aspe.hhs.gov/poverty-guidelines

Neighborhood Health Centers of the Lehigh Valley

955 Attachment C
Review Date: 04/25/2022

Sliding Fee Scale Program Application

Patient Name:_____ **MRN**_____

If wish to apply for discounts for essential services (our sliding fee program), please complete the information below:

Household Information		
Name	**Date of Birth**	**Social Security Number**

Household Income					
Name	**Amount**		**Frequency (Circle One)**		**Employer:**
You	**$**		Weekly Monthly Yearly		
Spouse/Partner	**$**		Weekly Monthly Yearly		
Children	**$**		Weekly Monthly Yearly		
Other	**$**		Weekly Monthly Yearly		
TOTAL	**$**		Weekly Monthly Yearly		
Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	

I swear that the information given by me on this application is true and correct to the best of my knowledge and belief. I agree that any false information, and/or lies may disqualify me in the future for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to tell NHCLV if there is an important change in my income (the money I make). If acceptance to the sliding fee program is obtained under this application, I will follow all rules and regulations of NHCLV. I hereby confirm that I read this statement and I understand it and had a chance to ask questions if I did not understand something in it.

Date:_____ Name (Print):_____

Signature:_

Neighborhood Health Centers of the Lehigh Valley

955 Attachment C
Review Date: 04/25/2022

Sliding Fee Scale Program Application

Nombre del paciente:_____ **MRN:**_____

Si desea solicitar un descuento, por favor complete la siguiente información:

Nombre	Fecha de nacimiento	Número de seguro social

Ingreso del hogar

Nombre	Cantidad	Frecuencia (círculo uno)	Empleador:
Paciente	$	Semanal Mensual Anual	
Cónyuge/pareja	$	Semanal Mensual Anual	
Niños	$	Semanal Mensual Anual	
Otros	$	Semanal Mensual Anual	
TOTAL	$	Semanal Mensual Anual	

Otros ingresos	Ud.	Pareja	Niños	Otros	Subtotal
Seguridad social					
Asistencia pública					
Pensión de jubilación					
Cupones de alimentos					
Manutención infantil, pensión alimenticia					
Ingresos por intereses					
Otros					
				TOTAL	

Yo por el presente juro o afirmo que la información proporcionada en esta solicitud es verdadera y correcta al mejor de mi conocimiento y creencia. Estoy de acuerdo que cualquier falsa o falsificada información, u omisiones me pueden descalificar de consideración para el programa de descuento de tarifas y me someterá a sanciones bajo las leyes federales que pueden incluir multas y encarcelamiento. Además, acepto informar a NHCLV si hay un cambio importante en mis ingresos. Si la aceptación al programa de descuento de tarifas se obtiene bajo esta aplicación, cumpliré con todas las reglas y regulaciones del NHCLV. Por la presente reconozco que leer la anterior información y entenderla y ha tenido la oportunidad a hacer preguntas si necesitaba.

Fecha:_____ Nombre (imprimir):_____

Firma: _____

Neighborhood Health Centers of the Lehigh Valley

July 15, 2019

Daffy Duck
1234 Looney Lane
Allentown, PA 18102

Patient: Duck, Daffy

PAYMENT PLAN AGREEMENT

Dear Daffy

As per our conversation on CONVERSATION DATE, below please find an outline of your agreed payments towards your outstanding balance of $ TODAY. Your payments will commence on START DATE and this does not include any other balance you would accrued in the interim.

Payments schedule is as follows:

1. Payment month
2. Payment month
3. Payment month
4. Payment month
5. Payment month

If you have questions, do not hesitate to contact our office at 610-820-7605.

Teresa Rivera

Cc:
Enc:

Neighborhood Health Centers of the Lehigh Valley

Patient Name:_____ **MRN**_____

Limited Income Statement

For the purpose of applying for Neighborhood Health Centers of the Lehigh Valley FQHC sliding-fee discount, I have not received any income for the last four weeks including but not limited to employment, Social Security benefits, Veterans Assistance benefits, pension, unemployment, Temporary Assistance for Needy Families (TANF), General Assistance, stipends, child support, alimony, workers compensations benefits, rental income, self-employed income and any under the table payments. I acknowledge and agree the statement noted within this Limited Income Statement, and understand that my application will be taken away if found not to be true.

If no income, please describe your living situation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

By signing this you are agreeing that the information above is accurate and correct.

_____ _____

Applicant Signature **Date**

Neighborhood Health Centers of the Lehigh Valley

Patient Name:_____**MRN**_____

DECLARACIÓN DE INGRESOS LIMITADOS

Con el propósito de solicitar el programa de descuento de tarifas de los Neighborhood Health Centers the Lehigh Valley no he recibido cualquier ingreso durante las últimas cuatro semanas incluyendo perc no limitado al empleo, beneficios de seguro social, beneficios de VA, pensión, desempleo, TANF, asistencia general, estipendios, manutención de menores, pensión alimenticia, beneficios de compensación de trabajadores, ingresos por alquiler, ingresos por cuenta propia y cualquier pago bajc mesa. Reconozco y acepto la declaración señalada dentro de esta declaración de ingresos limitada, y entiendo que mi solicitud será quitada si se encuentra no es verdad.

Si no tiene ingresos, por favor describa su situación de vida:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Al firmar esto usted afirma que la información anterior es exacta y correcta.

_____ _____

Firma del solicitante: **Fecha:**

Neighborhood Health Centers of the Lehigh Valley

One Day Sliding Fee Discount Program Consideration Request

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Estimated Household Monthly Income (how much money comes into the house on a monthly basis): $_____.00 ***This total amount is for all adults living in the same house. There are _____ people in my household.***

I understand that I am asking for Neighborhood Health Centers of the Lehigh Valley (NHCLV) to allow me to receive care today under the health center's Sliding Fee Discount Program.

I understand that this is a **One-Day** request for the Sliding Fee Discount Program based on my household size and income as stated above. I also understand that to have this program apply to my care for more than just today I must provide proof of household income before my next appointment. Until I provide proof of one month's household income, I will have to continue filling out this One Day Request Form each day of service (no exceptions).

If I receive coverage through insurance the Sliding Fee Discount Program could still be used as a secondary program for me but would not have to be primary (in other words, this program could be used to help with high co-pays). I still need to provide proof of income either way to be part of the Sliding Fee Discount Program under NHCLV.

_____

Name of Person Requesting Sliding Fee Program Date

_____

NHCLV Employee Name Date

Patient MRN:_____

Solicitud de consideración para el programa de descuento de tarifa de un día

Nombre: _____

Dirección: _____

Ciudad: _____ **Estado: _____Código Postal: _____**

Número de teléfono: _____ **Correo electrónico: _____**

Ingreso mensual estimado del hogar (cuánto dinero entra en la casa mensualmente):
$_____.00 ***Esta*** cantidad ***total*** es para todos los adultos que viven en la misma ***casa. Hay _____ personas en mi casa.***

Entiendo que estoy solicitando que Neighborhood Health Centers of the Lehigh Valley (NHCLV) me permitan recibir atención hoy bajo el Programa De Descuento De Tarifas

Entiendo que esta es una solicitud de **Un Día** para el Programa De Descuento De Tarifa según el tamaño y los ingresos de mi hogar, como se indicó anteriormente. También entiendo que para que este programa se aplique a mi atención más allá de hoy, debo proporcionar prueba de los ingresos del hogar antes de mi próxima cita. Hasta que proporcione prueba de los ingresos del hogar de un mes, tendré que seguir llenando este formulario de solicitud de un día cada día de servicio (sin excepciones).

Si recibo cobertura a través de un seguro y luego el Programa De Descuento De Tarifa aún podría usarse como un programa secundario para mí, pero no tendría que ser primario (en otras palabras, este programa podría usarse para ayudar con copagos altos). Aún necesito proporcionar comprobante de ingresos de cualquier manera para ser parte del Programa De Descuento De Tarifa bajo NHCLV.

_____

Nombre de la persona que solicita el programa de descuento de tarifas Fecha

_____

Nombre del empleado de la NHCLV Fecha

Patient MRN:_____

Attachment G: Additional Services Fee Schedule

Medical & Behavioral Health Services Sliding Fee Visit Prices

(Effective 7/1/22)

Office Visit Prices

- Slide A - $20
- Slide B - $35
- Slide C - $45
- Slide D - $55
- 100% Patient Responsibility – collect $130 and the patient will get a bill for the remaining charges

Behavioral Health as Second Service on the same day Visit Prices

- Slide A - $10
- Slide B - $15
- Slide C - $20
- Slide D - $25
- 100% Patient Responsibility – collect $130 and the patient will get a bill for the remaining charges

Nurse Visit Prices (now excludes BC refills, see Women's Health services)

- Level 1 - $10 (one service)
- Level 2 - $15 (two or more services)
- Blood draws and blood pressure checks are free and do not count toward number of services provided

COE Care Manager standalone visit (Diehl, Hills, Hinton, Otto, Soto)

- Slide A - $0
- Slide B - $5
- Slide C - $10
- Slide D - $15
- 100% Patient Responsibility – $25

Women's Health Sliding Fee Visit Prices (effective 07/1/21)

NEW! Women's Health Visit includes pap smear**

- Slide A - $25
- Slide B - $50
- Slide C - $65
- Slide D - $80
- 100% Patient Responsibility – collect $185 and the patient will get a bill for any remaining charges

**Sliding Fee patients who get a bill from Quest for their pap smear should bring it to the health center ASAP to resolve

NEW! Non-LARC Birth Control Nurse Visit 3-month Refill (pills, patches, rings, Depo & a pregnancy test)

- Slide A - $0
- Slide B - $15
- Slide C - $25
- Slide D - $35
- 100% Patient Responsibility - $70

Formulary LARC (Liletta) Device & Insertion Office Visit

- Slide A - $40
- Slide B - $50
- Slide C - $60
- Slide D - $70
- 100% Patient Responsibility – $100

Non-Formulary LARC (Nexplanon, Paragard) Device & Insertion OV

- Slide A - $100
- Slide B - $125
- Slide C - $150
- Slide D - $200
- 100% Patient Responsibility – $450