

Sliding Fee Discount Program For Medical and Dental Services

❗ Please read this before completing the Sliding Fee Discount Program application.

Shasta Community Health Center's mission is to provide quality health and dental care services to everyone. We are a private, nonprofit, federally funded health care program with locations in Redding, Anderson, and Shasta Lake. We bill most insurances and we accept patients without regard to their financial status. We offer a wide range of services to patients through the sliding-fee discount program. This program helps ensure that cost is not a barrier to anyone in our community seeking health care services.

To determine your eligibility for this federally funded program, documentation of your income (or lack of income) and household size is required. You must update this information at least annually to continue your participation in the program. This information is only used to calculate your discount and is kept completely confidential. If you have a high insurance deductible, you may be eligible for the Sliding Fee Discount Program.

If you qualify for the sliding fee program, you will be required to pay a minimum fee of \$15.00 - \$55.00. Your payment is required at the time of service.

You must complete the financial information form every year to determine your eligibility and discount. This information includes:

- ✓ Your total household income from all sources before taxes.
- ✓ Number of household members living in your household.
- ✓ You may be asked to provide proof of your total household income. This can be in the form of check stubs, bank statement, tax returns, or any other document that proves your household income.

Your discount may vary if your income changes.

Sliding Fee Discount payments are refundable whenever SCHC receives payment from your insurance for that date of service.

Services offered under the SCHC Sliding Fee Discount Program are limited to those deemed medically necessary by appropriate Center staff. Cosmetic, elective, or job-mandated health services do not qualify for the Sliding Fee Discount Program.

Radiology:

There are separate charges for performing and reading an x-ray. MDI offers a discount program, but it is a separate program. Please make discount arrangements directly with MDI.

Special Procedures:

Your health care provider may order special diagnostic studies (such as a sonogram or CT) not performed at SCHC. You will be responsible for 100% of those charges and must arrange to pay the facilities that provide them.

❓ Please let us know if you have any questions about our programs or services. We are here to help! You can contact our Billing Department at (530) 246-5934.



Sliding Fee Application



Personal Information: Give us some details about you and your household.

Patient Information

Last Name: _____ First Name: _____

Middle Initial: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Head of Household

This is usually the person who makes the most money in the home.

Same as patient? Yes No - If no, please let us know who is Head of Household:

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient: _____ Date of Birth: _____

Other People in the Household <i>(People who share all money made and bills - children too)</i>	Relationship to Head of Household	Date of Birth
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
TOTAL MEMBERS OF HOUSEHOLD		



Financial & Household Information: Tell us how much money you and the people in your household make.

Section A: How much money is made from all jobs, including self-employment?

Monthly \$ _____

Weekly \$ _____

Every 2 Weeks \$ _____

Twice a Month \$ _____

TOTAL (A) \$ _____

Section B: Other Sources of Money	Monthly Total
Child Support/Alimony	\$ _____
Unemployment	\$ _____
Disability/Workers Comp	\$ _____
Interest/Dividends	\$ _____
Social Security/SSI/Survivors Benefits	\$ _____
Pensions	\$ _____
Rental Income	\$ _____
Public Assistance <i>(not food stamps)</i>	\$ _____
Education Assistance	\$ _____
TOTAL (B)	\$ _____



Sign Here: By signing below you are saying that you agree to the statement in the box.

I know that giving false information may disqualify me for discounts. I also know, if disqualified, I will have to pay for the full fee and will not be eligible for the Sliding Fee Program.

I know that just because I apply for a discount does not mean I will get a discount. I also know that if I do not tell SCHC about any changes to how much money I make or the amount of people in the house, SCHC may immediately take away any discounts.

I know that information on this form will only be shared internally for purposes of the Sliding Fee Program.

Person Responsible for Paying

Sign: _____ **Date of Birth:** _____

Name & Relationship: _____ **Date:** _____

This form does not bind other agencies to honor the given discount and they may ask for more information.

--- OFFICE USE ONLY ---

Take the number reported in (A) and times it by the appropriate amount to get (A*)
 Weekly: x 4.33 Every 2 Weeks: x 2.167 Twice a Month: x 2

Household size: _____	Monthly Income:	Category:	Total Annual Income: \$ _____
	Wages (A*): \$ _____	_____ (A, B, C, D or Self)	
	Other (B): \$ _____	Fee: \$ _____	
	TOTAL: \$ _____ (A* + B)		
Reviewed By: _____	O&E Referral: _____	Expiration Date: _____	