Shasta Community Health Center
a californiahealth+ center

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 accept all patients regardless of their insurance or 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.

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MRN: _____

Employee ID #: _____
Office Use Only

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 Home *(People who share all money made and bills - children too)*	**Relationship to Patient**	**Date of Birth**
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
	TOTAL PEOPLE	

Would you like to see if you qualify for our Sliding Fee Discount Program?

Please note that if you choose not to complete this application, you will **not qualify for any discounts under our Sliding Fee Discount Program and may be responsible for the full cost of your medical or dental care.*

☐ Yes (please move on to the next section)

☐ No (please sign and date below and return this form)*

Sign: _____ **Refusal Date:** _____

MRN: _____

Employee ID #: _____
Office Use Only

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

How much money is made from all jobs? (A)

- ☐ Monthly $ _____
- ☐ Weekly $ _____
- ☐ Every 2 Weeks $ _____
- ☐ Twice a Month $ _____

Is anyone in your household self-employed?

☐ Yes ☐ No

If yes, how much money is made every month? $ _____

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 *(not food stamps)*	$
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*): $ _____ Other (B): $ _____ **TOTAL: $ _____** **(A* + B)**	_____ (A, B, C, D or Self) Fee: $ _____	$ _____

Reviewed By: _____ O&E Referral: _____ Renewal Date: _____