COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA
SLIDING FEE INFORMATION

Thank you for selecting Community Health Centers of Southern Iowa. Part of the mission for CHCSI is to provide quality services to you and your family. In doing so, CHCSI offers a sliding fee adjustment for patients and members of their family (as defined below) who fall below 200% of the poverty guidelines as set forth by the Federal Government. Income levels are based on total "family" income, family is defined below. The amount of the discount and the income ranges for those discounts are set by CHCSI's Board of Directors and approved by the Federal Government. Income guidelines are revised annually. Current discounts and income guidelines are available at all Community Health Center of Southern Iowa sites.

The sliding fee application will cover all medically necessary medical, behavioral and dental services. The costs of procedures, labs, tests and provider visits that are deemed medically necessary will qualify for the sliding fee discount. The costs of procedures, labs, tests and provider visits that are deemed optional, cosmetic or experimental will be the responsibility of the patient requesting the services at 100% of the regular rate charged. Even if services are ordered by a provider, it does not necessarily mean that they are medically necessary.

DEFINITIONS

Family – A family means those persons within the same household (including their dependents / partner) who are applying for the sliding fee discount using their combined income.

Individual – An individual is a person 18 years old or over who has verifiable income using the list below **(*)**.

INCOME VERIFICATION

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify CHCSI of that change. CHCSI reserves the right to verify income with an employer at any time. **(*) Patients are required to provide at least one of the following items as verification of income.**

- **Previous year tax return**
- **Previous year W-2 form(s)**
- **Current pay stubs (last 4 weeks, if possible)**
- **Lay-off notification from last employer**
- **Current information from unemployment office**
- **Denied Medicaid application and reason for denial**
- **Pay stubs from unemployment (last 4, if possible)**

If you were not required to file the prior year's income tax return, or you receive any of the following types of income, documentation must be submitted showing the amounts of each received by any member of the household.

- **Child Support**
- **Food Stamps**
- **Welfare Assistance**
- **Social Security**

- **Unemployment**
- **Self Employment Income**
- **Alimony**
- **Retirement Income**
- **Worker's Compensation**
- **Disability Income**
- **Any Other Income**

ELIGIBLE FEES

Medical, Mental Health and Dental services that are provided at CHCSI are eligible for the sliding fee discounts. **Previous charges, OWI assessments, elective procedures and outside services are NOT ELIGIBLE for a sliding fee discount. Deductibles ARE eligible for sliding fee discounts.**

MINIMUM CHARGE

There is a minimum medical, mental health and dental charge for all sliding fee visits, as approved by the CHCSI Board of Directors. The minimum charge **MUST** be paid at the time of service regardless of insurance coverage.

ADDITIONAL INFORMATION

Payment is required when services are rendered. Timeliness in completing this application is important. Your application for the sliding fee discount **will not** be approved until **complete** documentation is received. Until you are approved for a sliding fee discount, you will be responsible for the full charges associated with services you receive from CHCSI unless any amounts are covered by other third party sources. Once the application is complete, please return it to the office where you receive services. I f you have any questions, staff at the office you receive services at will assist you. Thank you.

COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA
SLIDING FEE APPLICATION

Patient's Name _____ Today's Date _____

Home Address _____ City _____

State _____ County _____ Zip Code _____ Sex: Female Male

Date of Birth _____ Social Security No. _____

Home Telephone _____ Work No. _____ Emergency No. _____

Marital Status of Patient: Single Married Separated Divorced Widowed

Employer / School _____ Occupation _____

Employer's Address _____

Do you have any other insurance? Yes No If so, what kind? _____

Is your employment seasonal? Yes No

Is your employment related to agriculture? Yes No

Number of people in your household? _____

Are you eligible for Medicaid? Yes No

Annual Gross Income (all adult members of household)? **$** _____

FINANCIALLY RESPONSIBLE PARTY:

Name _____ Date of Birth _____

Relationship to Patient _____ Social Security No. _____

Home Address _____

City _____ State _____ Zip Code _____

Home Telephone _____

FAMILY SIZE: (*If additional space is needed, please add to back of page*)

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

INCOME:

	Current Monthly	Last 12 Months Total
Wages or self employment	$ _____	$ _____
Social Security / Public Assistance	$ _____	$ _____
Unemployment / Worker's Compensation	$ _____	$ _____
Alimony or Child Support	$ _____	$ _____
Pensions / Retirement Income	$ _____	$ _____
Food Stamps / Welfare Assistance	$ _____	$ _____
Disability Income	$ _____	$ _____
Any Other Income	$ _____	$ _____

I declare under penalty of perjury, under the laws of the State of Iowa, that all statements contained in this application and accompanying documents is true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial of application.

I have read the Sliding Fee Application and I understand that payment is due at the time of service. If documentation of income verification is not given to CHCSI within 30 days of this application, the application will no longer be valid and you must reapply. Thank you in advance for your cooperation.

SIGNATURE _____ **DATE** _____

For Office Use Only:

Qualifies for: _____ **%** Discount Ineligible

Date of Determination: _____

Signature of person making eligibility determination: _____

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