RURAL HEALTH, INC.
APPLICATION FOR SLIDING FEE DISCOUNT

Appendix B

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:________________

Name of Employer:_______________________________________ Work Phone:____________________

Address:____ Monthly Gross Pay:________________

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 Rural Health, Inc. 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 Rural Health, Inc. immediately of any change in my household's financial status;
- If applicable, this discount will be applied only to the amount due after my insurance pays the amount for which I am covered.
- Some procedure or services may not be covered by this discount.

I swear / 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:__________________
Expiration Date:______________________________

ACCOUNT: ________ ________ ________ ________ ________ ________ ________

General Policy:

Rural Health, Inc. offers a Sliding Fee Discount to all patients to who are uninsured or under-insured.
Charges will be discounted based on patient's ability to pay. (Subject to eligibility).
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 Rural Health, Inc., Patient Service Representative for a Sliding Fee Discount Application.
Complete the application in full.
Attach the most recent 30 day's proof of income.
Return to a Rural Health, Inc., 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:

Applicant's who indicate they and other member of their household receive no income must complete the Rural Health, Inc. Self Declaration of No Income Form and include it with the completed Sliding Fee Discount Application.

Applicant's that indicate that they and other members of their household are living with other friends or family, must provider 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 Rural Health, Inc. 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 sliding fee discount program.

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

Acquisition Fees:

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

Sliding Fee Program - Nominal Charges and Discount Levels

The Board of Directors has approved the following multiple discount levels: **Appendix A**

Percent of Poverty	1-100%	101 to 125%	126 to 150%	151 to 175%	176 to 200%	Over 200%
Patients Responsibility	Level A	Level B1	Level B2	Level B3	Level B4	Level C
Medical Professional Services- Family Medicine, OB/GYN, Internal Medicine, Behavioral Health Dietitian (MNT)	$10	$15	$20	$25	$30	100% of charges
Mental Health Service LCSW Individual Counseling, Group Counseling (per individual)	$5	$8	$10	$12	$14	100% of charges
Dental Services **Preventative** Exam, bitewings, x-rays, Adult Prophy, consultation	$20	$25	$30	$35	$40	100% of charges
Preventative - Other Perio maintenance, full mouth debridement, root plane and scaling (per quad)	$40	$45	$50	$55	$60	100% of charges
Minor (per tooth) Amalgam, resin, extraction, filling, post & core, build up	$40	$45	$50	$55	$60	100% of charges
Major (per tooth) Crown, Root Canal Therapy	$350	$360	$370	$380	$390	100% of charges
Procedure Only Ultrasound Only	$10	$15	$20	$25	$30	100 % of charges
3rd party Lab (Quest) (excluding the Drug testing per Controlled Substance Policy, patient billed by Quest)	$10	$15	$20	$25	$30	Full Rate from Quest; Patient billed by Quest
Supply Cost: IUDs; Nexplanon, injections; Immunizations/vaccines	Acquisition cost	Acquisition cost	Acquisition cost	Acquisition cost	Acquisition cost	100 % of charges
Social Service/Enabling Services by Case Manager, Case Manager Assistant, Outreach Staff, Health Education Staff	$0	$0	$0	$0	$0	$0

Effective 3/20/2019

RURAL HEALTH, INC.
2022 Sliding Fee Scale **Effective January 12, 2022**

DISCOUNT LEVEL BASED ON FAMILY INCOME & SIZE **APPENDIX A**

	Level A		**Level B1**		**Level B2**		**Level B3**		**Level B4**		**Level C**
FAMILY	**<100% OF**		**<125% OF**		**<150% OF**		**<175% OF**		**<200% OF**		**>200% OF**
SIZE	**POVERTY LEVEL**		**POVERTY LEVEL**		**POVERTY LEVEL**		**POVERTY LEVEL**		**POVERTY LEVEL**		**POVERTY LEVEL**
	1-100%		**101 to 125%**		**126 to 150%**		**151 to 175%**		**176 to 200%**		**Over 200%**
1	0 -	13,590	13,590.01	16,988.00	16,988.01	20,385.00	20,385.01	23,783.00	23,783.01	27,180.00	27,180.01
2	0 -	18,310	18,310.01	22,888.00	22,888.01	27,465.00	27,465.01	32,043.00	32,043.01	36,620.00	36,620.01 and over
3	0 -	23,030	23,030.01	28,788.00	28,788.01	34,545.00	34,545.01	40,303.00	40,303.01	46,060.00	46,060.01 and over
4	0 -	27,750	27,750.01	34,688.00	34,688.01	41,625.00	41,625.01	48,563.00	48,563.01	55,500.00	55,500.01 and over
5	0 -	32,470	32,470.01	40,588.00	40,588.01	48,705.00	48,705.01	56,823.00	56,823.01	64,940.00	64,940.01 and over
6	0 -	37,190	37,190.01	46,488.00	46,488.01	55,785.00	55,785.01	65,083.00	65,083.01	74,380.00	74,380.01 and over
7	0 -	41,910	41,910.01	52,388.00	52,388.01	62,865.00	62,865.01	73,343.00	73,343.01	83,820.00	83,820.01 and over
8	0 -	46,630	46,630.01	58,288.00	58,288.01	69,945.00	69,945.01	81,603.00	81,603.01	93,260.00	93,260.01 and over
For family sizes greater than 8, add to the upper limit, for each additional family member:											
9+	4,720		4,720.01 to 5,900.00		5900.01 to 7,080.00		7,080.01 to 8,260.00		8,260.01 to 9,440.00		9,440.01 and over
Patient is responsible to pay for services in accordance with the attached Appendix A											

2022 Federal Poverty Guidelines