**RURAL HEALTH, INC.**
**APPLICATION FOR SLIDING FEE DISCOUNT**

**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 |

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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:_____

*** Monthly____(once) / Bi-Weekly____ (every two weeks) / Twice Monthly____ (two times a month) / Weekly _____

Address:_____ Monthly Gross Pay:_____

Name of Employer:_____ Work Phone:_____

*** Monthly____(once) / Bi-Weekly____ (every two weeks) / Twice Monthly____ (two times a month) / Weekly _____

Address:_____ Monthly Gross Pay:_____

Other Income (includes social security, unemployment, pensions, alimony, other aid, etc.)

Source:_____ Amount:_____

Source:_____ Amount:_____

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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:_____

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OFFICE USE ONLY: Total Family Annual Income:_____ Authorized by:_____
Discount Assigned:_____Level _____Checked by:_____
Expiration Date:_____ InternalAuditComplete:

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 proof of income (**Acceptable Proof of Income listed below)**.
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 filed Income Tax Returns'** **1099 Form**
**Letter from Employer on company letterhead** **Alimony**
**Most current months' pay stubs (30 days) including Tips** **Military Benefits**
**Unemployment Letter of Benefit** **W-2 forms** **Other**
**Social Security / Disability / Retirement or Veterans, Letter of Benefit**

## Sliding Fee Discount Patient Information

**No Income:**

Applicants' who indicate they and other members of their household, 19 and older, 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. (Appendix C)

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<br>Occlusal Adjustments | Whitening<br>Occlusal Guards(bite/mouth guards) |

**Acquisition Fees:**

- Supplies: IUD's, Nexplanon – patient pays Acquisition cost
- Services: Injections: 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:**

| 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** |
| | | | | | | |

**RURAL HEALTH, INC.**
**2024 Sliding Fee Scale** **Effective January 12, 2024**

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

| | 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 - 15,060 | 15,060.01 18,825.00 | 18,825.01 22,590.00 | 22,590.01 26,355.00 | 26,355.01 30,120.00 | 30,120.01 |
| 2 | 0 - 20,440 | 20,440.01 25,550.00 | 25,550.01 30,660.00 | 30,660.01 35,770.00 | 35,770.01 40,880.00 | 40,880.01 and over |
| 3 | 0 - 25,820 | 25,820.01 32,275.00 | 32,275.01 38,730.00 | 38,730.01 45,185.00 | 45,185.01 51,640.00 | 51,640.01 and over |
| 4 | 0 - 31,200 | 31,200.01 39,000.00 | 39,000.01 46,800.00 | 46,800.01 54,600.00 | 54,600.01 62,400.00 | 62,400.01 and over |
| 5 | 0 - 36,580 | 36,580.01 45,725.00 | 45,725.01 54,870.00 | 54,870.01 64,015.00 | 64,015.01 73,160.00 | 73,160.01 and over |
| 6 | 0 - 41,960 | 41,960.01 52,450.00 | 52,450.01 62,940.00 | 62,940.01 73,430.00 | 73,430.01 83,920.00 | 83,920.01 and over |
| 7 | 0 - 47,340 | 47,340.01 59,175.00 | 59,175.01 71,010.00 | 71,010.01 82,845.00 | 82,845.01 94,680.00 | 94,680.01 and over |
| 8 | 0 - 52,720 | 52,720.01 65,900.00 | 65,900.01 79,080.00 | 79,080.01 92,260.00 | 92,260.01 105,440.00 | 105,440.01 and over |
| For family sizes greater than 8, add to the upper limit, for each additional family member: | | | | | | |
| 9+ | 5,380.00 | 5,380.01 to 6,725.00 | 6,725.01 to 8,070.00 | 8,070.01 to 9,415.00 | 9,415.01 to 10,760.00 | 10,760.01 and over |
| **Patient is responsible to pay for services in accordance with the attached Appendix A** | | | | | | |

**2024 Federal Poverty Guidelines**

Rural Health, Inc.
Anna Medical Clinic/
Administration
513 North Main
Anna IL 62906-1668
P: 618-833-4471
F: 618-833-4900

Rural Health, Inc.
Dongola Medical Clinic
318 U.S. Highway 51 North
Dongola IL 62926-0277
P: 618-827-3545
F: 618-827-2300

Rural Health, Inc.
Goreville Medical Clinic
211 N. Broadway
Goreville, IL 62939-2323
P: 618-995-1002
F: 618-995-0204

Rural Health, Inc.
Metropolis Medical Clinic
1003 E. 5th Street
Metropolis, IL 62960-2311
P: 618-524-7499
F: 618-524-4560

Rural Health, Inc.
Vienna Medical Clinic
803 North 1st Street
Vienna IL 62995-1544
P: 618-658-2811
F: 618-771-8300

www.ruralhealthinc.org

## Self-Declaration of No Income Form

I, (applicant)_____, do hereby declare under penalty of perjury that I am currently unemployed and not receiving income from any source, including; unemployment, disability, SSI, pension, other household or family income.

I declare that the information stated above is true to the best of my knowledge and I understand that any misrepresentation may be grounds for termination of my or family/household sliding fee discount.

I agree that if my income status changes in any way, I will notify Rural Health, Inc. immediately at which time I will be required to complete a new sliding fee discount application and provide evidence of my household income.

_____ _____

Applicant Signature Date

Rural Health, Inc. Personnel

Reviewed by:_____

Date:_____