OZARKS COMMUNITY HEALTH CENTER SLIDING FEE SCALE APPLICATION

DATE: _____

NAME: _____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE:_____

DATE OF BIRTH:_____ SS#_____

Patient Reminder List:

- ☐ **Completed Sliding Fee application**
- ☐ **At least 2 consecutive months of income**
- ☐ **Return application and proof of income within 30 days of application date**

INCOME INFORMATION

Please list income for each member in your household (even if not related). If a member does not have income, please list "NONE". (YOU MUST PROVIDE 2 MONTHS OF CONSECUTIVE INCOME IN ORDER FOR US TO MAKE A DETERMINATION.)

YOU	SPOUSE	CHILDREN	OTHER PERSONS	TOTAL INCOME

NAME (LIST YOURSELF FIRST)	BIRTHDATE	INSURANCE	ACCT# (OFFICE USE ONLY)	OFFICE USE ONLY
				R__A__S__
				R__A__S__
				R__A__S__
				R__A__S__
				R__A__S__

TOTAL # OF HOUSEHOLD MEMBERS_____

APPLICATIONS WILL BE RENEWED EVERY **APRIL 30TH** ,EVEN IF THERE IS NO CHANGE IN INCOME. IF YOUR HOUSEHOLD INCOME OR SIZE CHANGES IN ANY WAY IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY THE HEALTH CENTER.

I DECLARE THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT I GIVE THE OZARKS COMMUNITY HEALTH CENTER PERMISSION TO INVESTIGATE ANY INFORMATION GIVEN IN THIS APPLICATION . I UNDERSTAND THAT THIS INFORMATION WILL BE KEPT CONFIDENTIAL. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE MINIMUM PAYMENT DUE AT EACH VISIT. I AM AWARE THAT THERE MAY BE ADDITIONAL CHARGES RELATED TO LABORATORY AND PATHOLOGY TESTS THAT MUST BE SENT OUT OF THE CLINIC. I AGREE THAT I WILL BE RESPONSIBLE FOR PAYING ALL COSTS ASSOCIATED WITH MY VISIT.

SIGNATURE _____ DATE_____

THIS SECTION TO BE COMPLETED BY OFFICE STAFF

ANNUAL HOUSEHOLD INCOME_____ #PEOPLE IN HOUSEHOLD_____ _____ R _____A _____S

PAYMENT LEVEL _____

MINIMUM CHARGE: Medical _____ Dental_____ DOES NOT QUALIFY_____

OCHC EMPLOYEE SIGNATURE _____

EFFECTIVE DATE_____EXPIRATION DATE_____

Dear Ozarks Community Health Center Patient:

Ozarks Community Health Center offers a discounted program to individuals/patients/families who qualify. Discounts for essential services are offered depending upon family size and income. If approved, the application will be able to help discount your visit. Your determined copay must be paid at the time of each visit. Your annual income and your family size will be used to calculate your determination.

Please bring the following with you when completing and returning your sliding fee scale application:

- Completed sliding fee scale application
- Name and Birthdates of everyone in the household
- Proof of income **(MUST BE 2 CONSECUTIVE MONTHS OF INCOME)**

	Yes	No	Amount
Social Security			
Supplemental Security Income (SSI)			
Alimony			
Child Support payments			
Money from other (friends, relatives, etc)			
VA Benefits			
Worker's Compensation			
Disability			
Rent received from land/buildings			
Any other income Explain:			
Has anyone recently applied for any of the above benefits? If yes, explain:			

It is required that we have 2 consecutive months of income in order to make a determination. Ozarks Community Health Center will only keep these applications on file for 30 days. After the 30 days has passed, it will be your responsibility to reapply and all pending charges will then become 100% your responsibility.

Ozarks Community Health Center 2019 Medical and Behavioral Health Sliding Fee Scale Program					
	100% or Below of Poverty Level	**101 - 133% of Poverty Level**	**134 - 166% of Poverty Level**	**167 - 200% of Poverty Level**	**> 200% of Poverty Level**
	Copay **$25**	Copay **$35**	Copay **$45**	Copay **$55**	Copay **100%**
Family Size	**SF Plan A**	**SF Plan B**	**SF Plan C**	**SF Plan D**	**Self Pay**
1	0	12,491	16,613	20,734	Over
	12,490	16,612	20,733	24,980	24,981
2	0	16,911	22,491	28,072	Over
	16,910	22,490	28,071	33,820	33,821
3	0	21,331	28,370	35,409	Over
	21,330	28,369	35,408	42,660	42,661
4	0	25,751	34,249	42,746	Over
	25,750	34,248	42,745	51,500	51,501
5	0	30,171	40,127	50,083	Over
	30,170	40,126	50,082	60,340	60,341
6	0	34,591	46,006	57,420	Over
	34,590	46,005	57,419	69,180	69,181
7	0	39,011	51,884	64,758	Over
	39,010	51,883	64,757	78,020	78,021
8	0	43,431	57,763	72,095	Over
	43,430	57,762	72,094	86,860	86,861
9	0	47,851	63,642	79,432	Over
	47,850	63,641	79,431	95,700	95,701
10	0	52,271	69,520	86,769	Over
	52,270	69,519	86,768	104,540	104,541
11	0	56,691	75,399	94,106	Over
	56,690	75,398	94,105	113,380	113,381
12	0	61,111	81,277	101,444	Over
	61,110	81,276	101,443	122,220	122,221
13	0	65,531	87,156	108,781	Over
	65,530	87,155	108,780	131,060	131,061
14	0	69,951	93,035	116,118	Over
	69,950	93,034	116,117	139,900	139,901
15	0	74,371	98,913	123,455	Over
	74,370	98,912	123,454	148,740	148,741

Ozarks Community Health Center 2019 Dental Sliding Fee Scale Program					
	100% or Below of Poverty Level	**101 - 133% of Poverty Level**	**134 - 166% of Poverty Level**	**167 - 200% of Poverty Level**	**> 200% of Poverty Level**
	Copay $30	50% of all charges	65% of all charges	80% of all charges	100% of all charges
Family Size	**SF Plan A**	**SF Plan B**	**SF Plan C**	**SF Plan D**	**Self Pay**
1	0 12,490	12,491 16,612	16,613 20,733	20,734 24,980	Over 24,981
2	0 16,910	16,911 22,490	22,491 28,071	28,072 33,820	Over 33,821
3	0 21,330	21,331 28,369	28,370 35,408	35,409 42,660	Over 42,661
4	0 25,750	25,751 34,248	34,249 42,745	42,746 51,500	Over 51,501
5	0 30,170	30,171 40,126	40,127 50,082	50,083 60,340	Over 60,341
6	0 34,590	34,591 46,005	46,006 57,419	57,420 69,180	Over 69,181
7	0 39,010	39,011 51,883	51,884 64,757	64,758 78,020	Over 78,021
8	0 43,430	43,431 57,762	57,763 72,094	72,095 86,860	Over 86,861
9	0 47,850	47,851 63,641	63,642 79,431	79,432 95,700	Over 95,701
10	0 52,270	52,271 69,519	69,520 86,768	86,769 104,540	Over 104,541
11	0 56,690	56,691 75,398	75,399 94,105	94,106 113,380	Over 113,381
12	0 61,110	61,111 81,276	81,277 101,443	101,444 122,220	Over 122,221
13	0 65,530	65,531 87,155	87,156 108,780	108,781 131,060	Over 131,061
14	0 69,950	69,951 93,034	93,035 116,117	116,118 139,900	Over 139,901
15	0 74,370	74,371 98,912	98,913 123,454	123,455 148,740	Over 148,741