PRISM HEALTH

Sliding Fee Eligibility Information

ELIGIBILITY FOR THIS PROGRAM IS BASED ON FINANCIAL NEED

How do I qualify?

All patients are asked to provide proof of household income and family size to qualify for the Sliding Fee Scale. New or established patients can apply for the Sliding Fee Scale program at any time. Information will be updated at least once every year, or anytime your income, household size and/or medical insurance status changes. It is your responsibility to keep an up to date sliding scale application with Prism Health.

Why does Prism Health need to know your household income?

In order to qualify for the Sliding Fee Scale program, income information from you is necessary.

----ALL INFORMATION IS CONFIDENTIAL----

Definition of Household:

Determination of household size for the sliding fee scale is based on federal guidelines. To determine a patient's household size, please include: yourself, spouse/domestic partner/partner, number of dependent children (even if they do not live with you).

Definition of Income:

Income is defined as total cash before taxes from all sources, which can include:

- Wages and salaries;
- Receipts from self-employment after deductions for normal operating expenses;
- Regular payments through public assistance, social security, longevity, unemployment, strike benefits, military allotments, disability, rental income, regular support from an absent family member or someone not living in the household (includes child support), government or private pensions, and regular insurance or annuity payments;
- Income from dividends (including permanent fund), interest, rent royalties, or income from estates or trusts.

Nominal Fees:

Patients receiving a full discount will be charged a "nominal fee" of $25.00 for medical visits (includes primary medical care), and $10 for behavioral health visits. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

Excluded Charges:

Charges from Quest Diagnostics are excluded from Prism Health's Sliding Fee Scale program, but you can apply for financial assistance directly through Quest. Please ask the front desk for additional information.

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Sliding Fee Scale Application

Date of Application: _____

Patient Name: _____

Responsible Party, if it is not the patient: _____

You must provide proof of income to qualify for the Sliding Fee Scale. This information must be updated at least annually, and any time your household income size and/or medical insurance status changes. Failure to provide Prism Health with information regarding any changes in your household, income, or insurance status will result in a suspension and possibly termination from the Sliding Fee Scale program.

Proof of income includes:

- **Pay Stubs** - Documentation of two concurrent months' worth of income.
- **Letter from Employer** – Dated within the last 6 months
- ed within last 6 months, verifying income.
- **Tax Documents** – Tax return from previous tax year or previous year's W2
- **Current Award/Benefit Letter** – E.g. Social Security, Pension, etc.
- **Zero Income Statement** – If you do not have any income, from any source, you can ask to sign a Zero Income Statement.

List your name and the names of ALL individuals in your household.

Name	Relationship	Age	Date of Birth	Annual Income	Employer
	SELF				

If you need more space, please continue on the back of this form.

How much money do you and all who live in your household bring in per:
Week $ _____Month $_____ Year $ _____

If you are not working, how are you meeting your monthly expenses?

☐ Savings ☐ Borrowing ☐ Other_____

List ALL that you and those living in your household receiving:			
	Yes	**No**	**Amount per month**
Salary or Wages	☐	☐	
Unemployment	☐	☐	
Social Security	☐	☐	
Pension/Retirement	☐	☐	
Rental Income/Dividends	☐	☐	
Interest	☐	☐	
Spousal Support	☐	☐	
Child Support	☐	☐	
Foster Care	☐	☐	
Public Assistance (ATAP)	☐	☐	
Permanent Fund	☐	☐	
Self-Employed (net amt)	☐	☐	
Worker's Comp Benefits	☐	☐	
Disability Benefits	☐	☐	
Other	☐	☐	

Total Monthly/Annual Household Income:_____

I certify that the statements regarding the persons and income in my household are true and correct to the best of my knowledge. I further understand if any information is found to be inaccurate, I may be denied a discount and/or subject to legal action for knowingly providing false information. I agree to notify Prism Health of all changes in income, address, living arrangements, number of household members, and/or other circumstances. I understand that the information given above will be kept confidential. I also understand that if I do not agree with any decision made concerning this application, I have the right to ask in writing for a review by the Director of Healthcare Operations.

I understand that Prism Health does not bill for lab fees, and these fees will be billed separately by Quest Diagnostics. I understand that it is my responsibility to apply for a discount with Quest Diagnostics. (To check the price of a specific lab test, or to inquire about Quest's financial services call 800-779-8857)

Signature: _____

Date: _____

Printed Name: _____

Thank you!

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OFFICE USE ONLY	
Annual or Monthly Income: _____	**Number of Household Members: _____**
FPL % _____	**Verified By: _____**
Date Application Received: _____	**Date Application Reviewed _____**
Income Verified With: ☐ **Pay Stubs**	☐ **Tax Documents** ☐ **Award / Benefit Letter**
☐ **Zero Income Statement** ☐ **Other _____**	**Qualified** ☐ **Yes** ☐ **No**
	Notification Letter Sent: _____