# Family Health Medical Services

95 East Chautauqua St., P.O. Box 168, Mayville, NY 14757

(716) 753-7107 Fax (716) 753-5367

## Sliding Fee Discount Application

***Discount will be effective fourteen (14) days prior to receipt of completed application and documentation***

Family Health Medical Services, PLLC would like to work with patients who do not have health insurance. We have put in place a sliding fee discount program for qualified patients. This fee schedule is based upon federal poverty guidelines. ***This program will discount your office visit but does NOT cover all charges. Please inquire with staff before having a procedure to make sure it is covered under your sliding fee. Immunizations and urine drug screens are NOT covered under this program.***

### Federal Poverty Guidelines

| Size of family unit | 100 Percent of Poverty | 125 Percent of Poverty | 150 Percent of Poverty | 175 Percent of Poverty | 200 Percent of Poverty |
|---|---|---|---|---|---|
| 1 | $11,170 | $13,963 | $16,755 | $19,548 | $22,340 |
| 2 | $15,130 | $18,913 | $22,695 | $26,478 | $30,260 |
| 3 | $19,090 | $23,863 | $28,635 | $33,408 | $38,180 |
| 4 | $23,050 | $28,813 | $34,575 | $40,338 | $46,100 |
| 5 | $27,010 | $33,763 | $40,515 | $47,268 | $54,020 |
| 6 | $30,970 | $38,713 | $46,455 | $54,198 | $61,940 |
| 7 | $34,930 | $43,663 | $52,395 | $61,128 | $69,860 |
| 8 | $38,890 | $48,613 | $58,335 | $68,058 | $77,780 |
| | 80% | 75% | 60% | 40% | 25% |

The following documentation is required to apply:

1. Completed and Signed Application
2. Denial Letter from Medicaid can be dated within the last year.
3. Copies of the last 8 weeks of income from all sources, for **ALL** members of the household
4. Photo ID

Revised on 02/12/13

Lori Carson

**Step # 1:** Contact Medicaid to inquire about eligibility. If you are not eligible, **please request a letter from Medicaid stating you are not eligible.** Until Family Health Medical Services, PLLC receives this letter your application will **NOT** be processed.

In the Jamestown area, contact Medicaid at 661-8246.
In the Dunkirk area, contact Medicaid at 366-4373.

**Step # 2:** Contact the "Get Covered Helpline." This is a countywide help line for uninsured and under insured people to assist them in obtaining healthcare coverage. This allows patients to obtain coverage for a variety of medical services, including prescriptions. The sliding fee discount offered by Family Health Medical Services, PLLC applies ONLY to care received in our offices.
*In all areas, call the Get Covered Helpline at (888) 753-7315.*

**Step # 3:** Complete the application and submit it with copies of **ALL** required documentation.
***And please note that all accounts have to be brought current before the sliding fee will take effect.***
*The following documentation is required to apply:*

1. Completed and Signed Application
2. Denial Letter from Medicaid
3. Copies of the **last 8 weeks** of income from **ALL** sources, for **ALL** members of the household
4. Photo ID

**Step # 4:** Mail or drop off your application at one of the Family Health Medical Services locations.
If you have questions or concerns, please call Lori Carson at 753-7107 at Ext. 4112.
If mailing, please send to:

Family Health Medical Services, PLLC
P.O. Box 168
Mayville, NY 14757
Attention: Lori Carson

**PLEASE NOTE:**

***If approved, the discount will be in place for six months. It is the patient's responsibility to reapply at that time .***Discount will be effective fourteen (14) days prior to receipt of completed application and documentation.

***Balance in full is due at time of service. If balance is not received in a timely fashion Family Health Medical Services, PLLC reserves the right to revoke the sliding fee discount, effective with the first missed payment***.

Revised on 02/12/13

Lori Carson

# Sliding Fee Discount Application

Patient Name _____ Date of Birth _____

Responsible Party _____ SS# _____

_____
Relationship to patient

Address _____

_____

_____

Telephone # _____

Employer Name _____

Employer Address _____

_____

_____

## For office use Only

| Approved Date | Denied Date |
|---|---|
| | |

Please return by: _____

Date Application given: _____ Given by: _____

Date Application Received: _____ Received By: _____

Given to: _____ Via: _____

Revised 04/05/12

**We require copies of all income your household received. All required information must be attached to this application or it will NOT be processed. Until application is approved, patient will be responsible for their bill in its entirety.**

Household Income:

Total for the previous 8 weeks

| | *Head of houshold* | *Spouse* | *Other dependents in houshold* |
|---|---|---|---|
| Wages/Income | | | |
| Self-Employment Income | | | |
| Unemployment | | | |
| Compensation | | | |
| Social Security | | | |
| Public Assistance | | | |
| Child Support | | | |
| Pension Income | | | |
| Rental Income | | | |
| Other (Please Specify) | | | |
| | | | |

Revised 04/05/12

Total Family Size .....

Family Members

| Name | Relationship |
| --- | --- |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |

Previous Insurance Company .....

Last date of insurance coverage .....

## *Charity Care*

*If patient qualifies for any percentage of the sliding fee application and still feels they are unable to pay for services rendered due to harship a letter will be required from the patient indicating such hardships. The letter and application will be reviewed by Management for approval and patient will be notified in writing as to the decision of their application.*

**Payment in full is due at time of service.**
If payments are not received in a timely manner, Family Health Medical Services, PLLC reserves the right to revoke the sliding fee agreement effective with the first missed payment.

By signing this application, I am certifying that household size and income information shown is correct. I understand that copies of all documentation are required before a discount application will be processed. I understand I will need to reapply and resubmit all documentation in six months or when there is a change in income or family size.

| Name | Signature | Date |
| --- | --- | --- |