SLIDING FEE DISCOUNT PROGRAM

"WHAT IS A SLIDING FEE DISCOUNT?"

NEW Health's Sliding Fee Discount enables NEW Health to discount qualifying service provided by NEW Health. All patients may be eligible and are encouraged to apply for the Sliding Fee Discount.

"HOW IS YOUR SLIDING FEE DISCOUNT DETERMINED?"

Sliding Fee Discount is determined based on your income level and members in your household. The Sliding Fee Discount amount is based on annual federal poverty guidelines. A percentage of the visit charges will be discounted. This Sliding Fee Discount may apply to all household members and may last up to one year with the appropriate documentation.

"HOW CAN I QUALIFY FOR A SLIDING FEE DISCOUNT?"

All individuals are eligible to apply for the Sliding Fee Discount. To qualify for Sliding Fee Discount, your household income must be below 200% of the federal poverty guidelines. NEW Health requests documentation of your income and the number of members in your household.

"WHAT TYPE OF DOCUMENTATION DO I NEED TO PROVIDE?"

NEW Health requests verification of income. Copies of wage statements, unemployment/pay stubs, etc. may be used for verification.

"WHAT HAPPENS IF I DON'T PROVIDE THE DOCUMENTATION?"

Self-declaration of income will be valid for up to six (6) months if verification of income is not available and an application is completed.

SLIDING FEE DISCOUNT APPLICATION

In order to determine your eligibility, please complete this application and provide household income verification. Verification documents include tax returns, wage statements, retirement statements, social security statements, bank statements. If documentation cannot be provided, this application may be used to self-attest a patient's household and household income.

This application applies to the Sliding Fee Discount for medical, dental, and behavioral health services and for NEW Health's Eligible Patient Pharmacy Discount.

Please apply this Sliding Fee Discount Application to: ❒Medical ❒Dental ❒Pharmacy

1. PATIENT INFORMATION

NAME:_____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE: (_____) _____-_____ BIRTH DATE: _____ SOC SEC #_____

MARITAL STATUS: _____ALTERNATIVE CONTACT PHONE #_____

2. MEMBERS OF HOUSEHOLD (please include yourself)

	NAME	BIRTHDATE	RELATIONSHIP
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

3. INCOME AND EMPLOYMENT

MONTHLY INCOME $_____ ANNUAL INCOME $_____

Are you currently employed? Yes ❒ No ❒

Source(s) of household income? _____

Do you have other health insurance, including Medical, Dental, Medicare, Medicaid, etc.? Yes ❒ No ❒
(If yes please provide below)

Name of Ins._____ Policy ID #_____

By signing below, I certify the information provided on this form is true and correct to the best of my knowledge. If the information provided on this form is false or information was deliberately withheld in order to become eligible, I acknowledge I will be responsible for the total charges incurred.

_____ _____
APPLICANT'S SIGNATURE **DATE**

Office Use only: V or N/V Discount %_____ Date_____ Initials_____

OFFICE USE ONLY

VERIFICATION GIVEN BY PATIENT

Pay Stub—Unemployment	❒
Tax Form 1040 P. 1	❒
W-2's	❒
1099's (Pension)	❒
Bank Statement / Loan Application	❒
Social Security Benefit Statement	❒
PHOTO ID	❒

Other: _____ ❒

Self-Declaration (no documentation provided) ❒

Qualifying Sliding Fee Discount: _____ %

Application is: Approved □ Denied □

Reason for denial:

_____

_____

_____

_____ _____

AUTHORIZED BY **DATE**