COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA
SLIDING FEE INFORMATION

Thank you for selecting Community Health Centers of Southern Iowa. Part of the mission for CHCSI is to provide quality services to you and your family. In doing so, CHCSI offers a sliding fee adjustment for patients and members of their family (as defined below) who fall below 200% of the poverty guidelines as set forth by the Federal Government. Income levels are based on total “family” income, family is defined below. The amount of the discount and the income ranges for those discounts are set by CHCSI’s Board of Directors and approved by the Federal Government. Income guidelines are revised annually. Current discounts and income guidelines are available at all Community Health Center of Southern Iowa sites.

The sliding fee application will cover all medically necessary medical, behavioral and dental services. The costs of procedures, labs, tests and provider visits that are deemed medically necessary will qualify for the sliding fee discount. The costs of procedures, labs, tests and provider visits that are deemed optional, cosmetic or experimental will be the responsibility of the patient requesting the services at 100% of the regular rate charged. Even if services are ordered by a provider, it does not necessarily mean that they are medically necessary.

DEFINITIONS

Family – A family means those persons within the same household (including their dependents / partner) who are applying for the sliding fee discount using their combined income.

Individual – An individual is a person 18 years old or over who has verifiable income using the list below (*).

INCOME VERIFICATION

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify CHCSI of that change. CHCSI reserves the right to verify income with an employer at any time. (*) Patients are required to provide at least one of the following items as verification of income.

- Previous year tax return
- Previous year W-2 form(s)
- Current pay stubs (last 4 weeks, if possible)
- Lay-off notification from last employer
- Current information from unemployment office
- Denied Medicaid application and reason for denial
- Pay stubs from unemployment (last 4, if possible)

If you were not required to file the prior year’s income tax return, or you receive any of the following types of income, documentation must be submitted showing the amounts of each received by any member of the household.

- Child Support
- Food Stamps
- Welfare Assistance
- Social Security
- Unemployment
- Self Employment Income
- Alimony
- Retirement Income
- Worker’s Compensation
- Disability Income
- Any Other Income

**ELIGIBLE FEES**

Medical, Mental Health and Dental services that are provided at CHCSI are eligible for the sliding fee discounts. Previous charges, OWI assessments, elective procedures and outside services are **NOT ELIGIBLE** for a sliding fee discount. Deductibles **ARE eligible** for sliding fee discounts.

**MINIMUM CHARGE**

There is a minimum medical, mental health and dental charge for all sliding fee visits, as approved by the CHCSI Board of Directors. The minimum charge **MUST** be paid at the time of service regardless of insurance coverage.

**ADDITIONAL INFORMATION**

Payment is required when services are rendered. Timeliness in completing this application is important. Your application for the sliding fee discount **will not** be approved until complete documentation is received. Until you are approved for a sliding fee discount, you will be responsible for the full charges associated with services you receive from CHCSI unless any amounts are covered by other third party sources. Once the application is complete, please return it to the office where you receive services. If you have any questions, staff at the office you receive services at will assist you. Thank you.
COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA
SLIDING FEE APPLICATION

Patient’s Name ____________________________________________ Today’s Date ______________________
Home Address __________________________________________ City ________________________________
State ____________ County ____________ Zip Code ____________ Sex: Female Male
Date of Birth __________________________ Social Security No. ____________________________
Home Telephone _________________ Work No. _________________ Emergency No. _________________
Marital Status of Patient: Single Married Separated Divorced Widowed
Employer / School ____________________________ Occupation ____________________________
Employer’s Address __________________________________________
Do you have any other insurance? Yes No If so, what kind? ____________________________
Is your employment seasonal? Yes No
Is your employment related to agriculture? Yes No
Number of people in your household? __________
Are you eligible for Medicaid? Yes No
Annual Gross Income (all adult members of household)? $ ____________________________

FINANCIALLY RESPONSIBLE PARTY:
Name ____________________________________________ Date of Birth __________________________
Relationship to Patient ____________________________ Social Security No. __________________________
Home Address __________________________________________
City ____________________________ State __________________________ Zip Code __________________________
Home Telephone ____________________________

FAMILY SIZE: (If additional space is needed, please add to back of page)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**INCOME:**

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Current Monthly</th>
<th>Last 12 Months Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages or self employment</td>
<td>$______________</td>
<td>$______________</td>
</tr>
<tr>
<td>Social Security / Public Assistance</td>
<td>$______________</td>
<td>$______________</td>
</tr>
<tr>
<td>Unemployment / Worker’s Compensation</td>
<td>$______________</td>
<td>$______________</td>
</tr>
<tr>
<td>Alimony or Child Support</td>
<td>$______________</td>
<td>$______________</td>
</tr>
<tr>
<td>Pensions / Retirement Income</td>
<td>$______________</td>
<td>$______________</td>
</tr>
<tr>
<td>Food Stamps / Welfare Assistance</td>
<td>$______________</td>
<td>$______________</td>
</tr>
<tr>
<td>Disability Income</td>
<td>$______________</td>
<td>$______________</td>
</tr>
<tr>
<td>Any Other Income</td>
<td>$______________</td>
<td>$______________</td>
</tr>
</tbody>
</table>

I declare under penalty of perjury, under the laws of the State of Iowa, that all statements contained in this application and accompanying documents is true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial of application.

I have read the Sliding Fee Application and I understand that payment is due at the time of service. If documentation of income verification is not given to CHCSI within 30 days of this application, the application will no longer be valid and you must reapply. Thank you in advance for your cooperation.

**SIGNATURE** ___________________________ **DATE** ____________________

---

**For Office Use Only:**

Qualifies for: % Discount | Ineligible

Date of Determination: __________________

Signature of person making eligibility determination: __________________

*Revised 7/2013*