HELPING HANDS PEDIATRICS, INC.

Sliding Fee Scale Requirements and Application

General Rules

Discount must be offered to all patients who meet eligibility criteria.

Eligibility criteria must be developed from the Federal Poverty Guidelines, based on family size and income.

Discounts will be all inclusive, covering visits, procedures, etc. per unit of service for any service available at the time the family is enrolling in services (not all services may be available).

Fee Scale

Clients between 0 -200% Federal Poverty Level might qualify to receive a discount.

All individuals who are uninsured, under-insured, or been denied for services may also qualify.

Clients may be responsible for a nominal fee for services. This will be determined by the fee schedule.

Determining Eligibility for Discounts

- The collection of family size and income information from client(s) is required
- Clients who decline to offer this information are ineligible for a discount
- The client(s) will be provided the application form to have completed or to bring the necessary documentation prior to the initial appointment.
- Billing staff, the clinician, or other representative from Helping Hands Pediatrics, Inc. will review the information and determine the fee(s) for service.
- The application for fee adjustment may be reviewed every 6-months or annually, but is required annually.

Recertifying Clients for Discount

Clients are re-certified once per year, or 6 months depending on the circumstances

The following documents are attached to this memo

- Discount Application Form
- Form must be completed prior to initial registration & updated as requested

- Sliding fee scale & costs for services prior to consideration according to Federal Poverty Guidelines

Other Protocol

Family must complete appropriate intake paperwork required for clinical practice following agreement to services

Required Documentation for Discounts

- Discount Application Form
- Proof of Income please provide one of the following:

  If Employed

  1040

  W2

  2-months of recent pay stubs

- Written statement by employer for change in status of income or coverage

  If Unemployed

  Public Assistance check stub/copy

  Social Security check stub or letter of award

  Certification Letter from Medical Assistance or Department of Social Services

  Completed zero income form

  Written statement from friend or relative with whom patient lives (if other forms not available)

  Letter of reference from a 501 (c)(3) organization, such as a church

- Proof of Address please provide one of the following:

  US Citizen

  Driver's license

  Verification of legal address via phone book, letter from homeless or abuse shelter

Any document (envelope) recently addressed to patient such as a utility bill

A written statement by relative or friend with whom patient lives

Immigrants

Form 1551

Form 194

Discount Application Form

Date of Completion _____Referral Source: _____

Patient Name

DOB

Race

Sex

Address _____

City State Zip Code _____

*Please complete the section below if you are over 18 years of age

Guardian/Parent

Name:

DOB

Race

Sex

Driver's License No.

SS#

Phone Numbers:

Home Office Cell Place(s) of employment Occupation/Trade *Please complete the section below if there is more than one person contributing to income
Guardian/Parent Name: DOB Race Sex Driver's License No. SS# Phone Numbers: Home Office Cell Place(s) of employment Occupation/Trade
Combined Annual Income

You understand you have a financial responsibility for services. This contract will be valid for a minimum of 6-months, but up to a one year period of eligibility starting on_____. You will need to be re-qualified for services on my anniversary date, which is _____ . You understand you must bring in current documentation at the point of my annual anniversary.

Patient / Guardian Signature _____

Staff Signature _____ Date Signed

_____

Number of persons living in your household: _____

Person(s) contributing to income:

Household Member(s) Household Income (Complete relevant column(s)) **Self**	**Spouse**	**Relative (providing Financial Support/amount)**	**Other Source(s) and amount of income**

Annual Income
Monthly Income
Bi-Weekly Income
Other Income

Supporting proof of documented income required

NOTE: Include income from all persons in household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.

I certify that the household size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved and will be provided as may be requested.

Name (Print) _____

Signature Date _____