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What is a Sliding Fee Schedule?

A discounted/sliding fee schedule is a set of discounts that is applied to a site's schedule of charges for services, based upon a written policy that is non-discriminatory. The fee schedules address the need for equitable charges for services rendered to patients. To determine the Sliding Fee Schedule, you qualify for we use your annual gross income to calculate the Federal Poverty Level (PFL) according to the most recent Federal Poverty Guidelines, to view the most recent FPL visit the website:

http://aspe.hhs.gov/poverty/index.cfm

We can provide a copy of the current Sliding Fee Schedule upon request.

Why a Sliding fee Schedule?

Federal requirements prescribe that a locally determined discounted/sliding fee schedule be used, and that services be provided either at no fee or a nominal fee, as determined by the provider.

How do I apply for Discount/Sliding Fee Schedule?

Bring proof if you qualify for a federal/state public assistance program, for example:

1. Social Security Disability Income (SSDi).
2. Temporary Assistance for Needy Families (TANF).
3. Free or reduced school lunch program.
4. Other public assistance programs.

If you are uninsured and want to apply you must fill out an application and provide the following information:

- **(original) current proof of income** (pay stubs not older than 30 days, w-2 or 1099, tax returns),
- **dependent(s) information** (Name, date of birth, and relation).

With this information, we can help you fill out the application and we will let you know that same day what Sliding Fee Schedule you qualify for.

***Sliding Fee Schedule is reviewed and updated every year from the date of enrollment.**

FOR STAFF USE ONLY. APPLICANT IS APPLYING FOR:

	SLIDING FEE SCALE PRIMARY CARE
	SLIDING FEE SCALE BEHAVIORAL HEALTH
	SLIDING FEE SCALE PAIN MANAGEMENT
	SLIDING FEE SCALE PSYCHIATRY
	SLIDING FEE SCALE HOMELESS
	SLIDING FEE SCALE PODIATRY
	SLIDING FEE SCALE OB/GYN
	SLIDING FEE SCALE RYAN WHITE
	SLIDING FEE SCALE ORTHOPEADIC

Helping People Heal
BARTZ-ALTADONNA Community Health Center
californiahealth+

I declare that the foregoing is true and correct.

_____ _____ _____

Client Name ***Client Signature*** ***Date***

☐ Applicant/Self

Dependents

Name: _____ Date of Birth: _____ Relation: _____

Name: _____ Date of Birth: _____ Relation: _____

Name: _____ Date of Birth: _____ Relation: _____

Name: _____ Date of Birth: _____ Relation: _____

Name: _____ Date of Birth: _____ Relation: _____

Family unit size **(including self)**: _____

For Office Use Only

Annual Gross Income: $ _____

Affidavit: _____ Affidavit of Income _____Support Affidavit _____ ***No Income*** Affidavit _____Self Employment

Proof of income

☐ Paystub ☐ Award Letter ☐ 1099 Form ☐ Tax Return ☐ w-2 Form

☐ Disability ☐ Cash Aid/Calfresh ☐ Other Income: _____

☐ Alimony ☐ Child Support ☐ Social Security ☐ TANF ☐ General Relief (GR)

% Of FPL: _____ **Sliding Fee Schedule:** _____ **Copay: $**_____

_____ _____

BACHC Staff Name **BACHS Staff Signature**