



43322 Gingham Avenue Suite 105
Lancaster, CA 93535
Ph. (661) 874-4050
Fx. (661) 874-4051

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:

| | |
|--------------------------|-------------------------------------|
| <input type="checkbox"/> | SLIDING FEE SCALE PRIMARY CARE |
| <input type="checkbox"/> | SLIDING FEE SCALE BEHAVIORAL HEALTH |
| <input type="checkbox"/> | SLIDING FEE SCALE PAIN MANAGEMENT |
| <input type="checkbox"/> | SLIDING FEE SCALE PSYCHIATRY |
| <input type="checkbox"/> | SLIDING FEE SCALE HOMELESS |
| <input type="checkbox"/> | SLIDING FEE SCALE PODIATRY |
| <input type="checkbox"/> | SLIDING FEE SCALE OB/GYN |
| <input type="checkbox"/> | SLIDING FEE SCALE RYAN WHITE |
| <input type="checkbox"/> | SLIDING FEE SCALE ORTHOPEADIC |



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

| | | | | |
|-------------------------------------|--|--|-------------------------------------|--|
| <input type="checkbox"/> Paystub | <input type="checkbox"/> Award Letter | <input type="checkbox"/> 1099 Form | <input type="checkbox"/> Tax Return | <input type="checkbox"/> w-2 Form |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Cash Aid/CalFresh | <input type="checkbox"/> Other Income: _____ | | |
| <input type="checkbox"/> Alimony | <input type="checkbox"/> Child Support | <input type="checkbox"/> Social Security | <input type="checkbox"/> TANF | <input type="checkbox"/> General Relief (GR) |

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

BACHC Staff Name **BACHS Staff Signature**

