Sliding Fee Scale Discount Program Application

How Does the Sliding Fee Scale Discount Program Work?
As a Federally Qualified Health Center (FQHC), Connect Health + Wellness (CHW)is required to provide a sliding fee scale discount program to patients who meet the eligibility guidelines. To determine if you are eligible for this discount, you will need to fill out & sign this application. The sliding fee scale discount application is used to determine eligibility for the sliding scale and to assess the level of discount assigned to the patient.

In addition to this application, you will need to provide CHW with the following documents to apply for the Sliding Fee Scale Discount Program:

Proof of income for you and anyone who resides/lives in your home. The following items may be used as proof of income:

+ W-2 forms
+ Two most current pay stubs
+ Income Tax Returns
+ Unemployment Benefits letter/Social Security Benefit Letter/Public Assistance Benefits Letter
+ If you are not working, and do not have a source of income, a letter of support from someone who is supporting you financially or the individual that you are living with.

Proof of Identification will also be required to the form of any two of the following **VALID and CURRENT** documents:

+ State Issued Driver's License
+ State Issued ID Card
+ Birth Certificate
+ Marriage License (For name Verification Only)
+ Employment ID Badge
+ Virginia Medicaid Identification Card
+ Utility Bill
+ Valid Passport
+ Alien Registration Card (Commonly Known as a "Green Card")

+ Patients will be granted a ONE visit exclusion from providing proof by providing self-attestation of income.
+ However, for any subsequent visit, without proof of income, the patient will be considered to fall within the "above 200% of the Federal Poverty Guidelines" and billed at 100% of the charge. The SDFS will be valid for one (1) year from the date proof of income is provided.
+ Patients will not be required to apply for insurance and be turned down as a prerequisite for eligibility for the SFDS.

Insured patients who are eligible for SFDS will be charged no more than the amount they would have owed under the SFDS based upon their pay class, subject to any contractual or other legal restrictions.

2025 Federal Poverty Guidelines	Slide A		Slide B				Slide C				Slide D				FULL Fee	
	Co-payment $15.00		Co-Payment $20.00				Co-Payment $30.00				Co-Payment $40.00					
	0%- 100% of FPG		101% to 150% FPG				151% to 175% FPG				176% to 200% FPG				201% of FPG	
Family Sixze :	Monthly	Annual	Monthly		Annual		Monthly		Annual		Monthly		Annual		Monthly	Annual
1	$1,304	$15,650	$1,317	$ 1,956	$ 15,807	$ 23,475	$1,969	$2,282	$23,632	$27,388	$2,295	$2,608	$27,544	$31,300		
2	$1,763	$21,150	$1,780	$ 2,644	$ 21,362	$ 31,725	$2,661	$3,084	$31,937	$37,013	$3,102	$3,525	$37,224	$42,300		
3	$2,221	$26,650	$2,243	$ 3,331	$ 26,917	$ 39,975	$3,353	$3,886	$40,242	$46,638	$3,909	$4,442	$46,904	$53,300		
4	$2,679	$32,150	$2,706	$ 4,019	$ 32,472	$ 48,225	$4,046	$4,689	$48,547	$56,263	$4,715	$5,358	$56,584	$64,300		
5	$3,138	$37,650	$3,169	$ 4,706	$ 38,027	$ 56,475	$4,738	$5,491	$56,852	$65,888	$5,522	$6,275	$66,264	$75,300		
6	$3,596	$43,150	$3,632	$ 5,394	$ 43,582	$ 64,725	$5,430	$6,293	$65,157	$75,513	$6,329	$7,192	$75,944	$86,300		
7	$4,054	$48,652	$4,095	$ 6,082	$ 49,139	$ 72,978	$6,122	$7,095	$73,465	$85,141	$7,136	$8,109	$85,628	$97,304		
8	$4,513	$54,150	$4,558	$ 6,769	$ 54,692	$ 81,225	$6,814	$7,897	$81,767	$94,763	$7,942	$9,025	$95,304	$108,300		
	$428	$5,140	$432	$ 642	$ 5,187	$ 7,704	$646	$749	$7,755	$8,988	$753	$856	$9,039	$10,272		

For Each additional person over 8 add the amount shown for each additional member.

There is no Sliding fee schedule for patients that are 200% or above the Federal Poverty Guidelines

IF YOU DO NOT WISH TO APPLY FOR THE DISCOUNTED SLIDING FEE SCALE AT THIS TIME, PLEASE CHECK THE BOX BELOW:

O I UNDERSTAND THAT I HAVE THE RIGHT TO DECLINE REDUCED FEE STATUS; HOWEVER, IF AT TIME MY FINANCIAL STATUS CHANGES, I CAN APPLY FOR REDUCED FEE STATUS AT THIS FACILITY.

Patient Information

Name (First)_____(Last)_____ Date of Birth_____

If you are over 18, do you live in someone else's home other than your family? ☐Yes ☐ No

Are you currently employed? ☐YES ☐NO

Is your spouse/partner currently employed? ☐YES ☐NO ☐N/A

Are any other family members who live with you, employed? ☐YES ☐NO ☐N/A

Household Members & Gross Income *(This includes all persons claimed on taxes meaning your children, spouse/partner)*

**** Proper proof of income documents must be provided for each household member**

Patients will not be refused treatment due to their inability to pay. Patients who are unable to pay their fees incurred for services or items received may apply for Budget Plan/Pay Agreement or speak with an CHW representative about requesting a hardship determination to waive or reduce fees. If a patient refuses to pay the balance of their bill, refuses to work with a financial counselor to assist them in the payment of their bill, is sent to collections by CHW but nevertheless continues to refuse to make payment thereon without requesting a hardship waiver, or is denied a hardship waiver by CHW, then CHW reserves the right to start the dismissal process of the patient from its services, through consultation with patient's provider and CHW's legal counsel.

Household Member Name	Relationship to Patient	Date of Birth	Monthly Income (Gross)	Insured? (Yes/No)	Student? (Yes/No)
1.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
2.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
3.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
4.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
5.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
6.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
7.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
8.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				

Statement of Understanding:

The information provided about family size and gross annual income from all sources is true, accurate and complete to the best of my knowledge. Information concerning my financial situation, means and ability to pay is given for the purpose of obtaining a discount on my accounts with Connect Health + Wellness (CHW) for my own and my family's benefit. I understand CHW will rely on such information to determine applicable discount rates for my account. I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the Commonwealth of Virginia.

I agree to report any change(s) in either my income or family size to CHW before or at my next contact or any contact by any family member with CHW. I know that the information I have given will continue to be relied upon until it is changed. I understand that my discount status will be reviewed on an annual basis and adjusted according to my family income and size at the time of review. If CHW has reason to suspect that the information I have given is untrue, inaccurate, or that I have not properly reported changes, CHW may initiate a review of my status.

APPLICATION MUST BE ACCOMPANIED BY PROOF OF FINANCIAL SITUATION BEFORE DISCOUNT WILL BE APPLIED. PROOF OF INCOME MUST BE PROVIDED WITHIN THIRTY (30) DAYS OF THIS VISIT IN ORDER TO CONTINUE REDUCED FEES FOR OTHER VISITS. FAILURE TO PROVIDE VERIFICATION WILL RESULT IN LOSS OF REDUCED FEES AND YOU WILL BE CHARGED FULL PRICE FOR YOUR VISIT.

My signature below indicates that all information I have provided is true to the best of my knowledge.

Signature _____ Date _____

APPLICATION MUST BE RENEWED ANNUALLY WITH UPDATED PROOF OF INCOME

NO SLIDING SCALE AVAILABLE FOR FOLLOWING SERVICES

The sliding scale discount is not applied to the following services which arise at the request ofemployers or parties, other than the patient: **Virginia DOT Physicals**