Community Dental

1102 S Virginia Street, Suite B- Hopkinsville, KY 42240
270-632-3088 (Phone) - 270-632-8212 (Fax)

Sliding Fee Discount Income Verification Guidelines
ATTACHMENT A

Please complete Sliding Fee Discount Application entirely. Please sign and return completed application and proof of income information to the health center within 14 days of the initial visit. Discount will start on the day proof of income is received.

Discounts will be based on household size and income. **Pennyroyal Healthcare Services, Inc.** recognizes families do not always fit the traditional model. PHCS identifies the definitions of a household, family and income as below:

A. **Household** consists of all the persons who occupy a house or apartment. Adult children living at home who are no longer dependent are considered a separate household. Roommates who share living arrangements but are not tied to one another through marriage, children or similar relationships are considered separate households. Those living with a friend or relative during a time of need, are also considered a separate household.

B. According to the Census Bureau a **family** is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

C. **Income** includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

We will contact you in writing if you are denied for any reason.
If approved we will send you a slide card identifying your assigned Slide Class. Please show the slide card to the receptionist at each visit. The Outreach Specialists will work with medical staff, pharmaceutical companies and local community resources to help provide medical and social needs, as needed. Outreach workers could utilize information from your application and income verification to apply for additional assistance, as needed.

Patients will not be discriminated based on age, gender, race, creed, disability, national origin or insurance status. Dignity, confidentiality and respect will be given to all who seek and/or are provided charitable services.

You must provide at least one of the following:

- Prior year W-2.
- Two most recent pay stubs.
- Letter from employer stating patient's income. Pennyroyal Healthcare Services, Inc. would prefer document be on letterhead and must include employer's name, address and phone number.
- Form 4506-T (if W-2 not filed).
- Form 1040, 1040A or 1040EZ.
- Social Security letter for fixed incomes such as social security, disability, pension, etc.
- SNAP benefits letter
- Free lunch school form, which must include household size and income.
- Most recent unemployment compensation documentation.
- Letter of reference on letterhead from any 501(c) (3) non-profit organizations such as homeless shelters or churches.
- Letter from the patient's medical provider stating patient is unable to work due to health condition, surgery, etc.
- Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business.

Pennyroyal Healthcare Services, Inc.

2025 Dental Sliding Fee Schedule
(Based on 2025 DHHS Federal Poverty Guidelines)
Effective February 2025

Poverty Level	Class A 100% or below	Class B 101%-125%	Class C 126%-150%	Class D 151%-200%	Class E > 200%
Family Size	$100	Pay 70%	Pay 80%	Pay 90%	Full Fee
1	$15,650	$19,563	$23,475	$31,300	$ 30,121
2	$21,150	$26,438	$31,725	$42,300	$ 40,881
3	$26,650	$33,313	$39,975	$53,300	$ 51,641
4	$32,150	$40,188	$48,225	$64,300	$ 62,401
5	$37,650	$47,063	$56,475	$75,300	$ 73,161
6	$43,150	$53,938	$64,725	$86,300	$ 83,921
7	$48,650	$60,813	$72,975	$97,300	$ 94,681
8	$54,150	$67,688	$81,225	$108,300	$ 105,441
For each additional person, add	$6,330				

**Patients are required to pay the full cost of labs and appliances (supplies) for dentures, crowns, bridges, extractions, root canals, etc

** Covered services include Preventative Dental Serivces (dentral screenings, oral hygi instructions, oral prophulaxis, topical application of fluoride, x-rays and imaging, and fil

Community Dental
1102 S Virginia Street, Suite B- Hopkinsville, KY 42240
270-632-3088 (Phone) - 270-632-8212 (Fax)

Community Dental Sliding Fee Scale disclaimer

CLASS A (100% OR BELOW) - $100 FEE
CLASS B (101%-125%) - 30% DISCOUNT
CLASS C (126%-150%) - 20% DISCOUNT
CLASS D (151%-200%) - 10% DISCOUNT
CLASS E (201% AND ABOVE) - RESPONSIBLE FOR FULL FEE

Covered Services

The following dental services **ARE** included under the nominal fee:

- Preventative Dental Services - dental screenings, oral hygiene instructions, oral prophylaxis, topical application of fluoride
- Basic dental services used to diagnose and treat disease, injury, or impairment in teeth - x-rays and imaging, fillings.

Non-Covered Services

Services that are **NOT** covered under the nominal fee ($100) but are provided under 100% of FLP at a discounted rate of 35% of our usual and customary fees. Examples of these fees not covered under the nominal fee include:

- Single Unit Crowns
- Extractions
- Root Canals
- Bridges
- Dentures
- Any other procedures that are not directly outlined as a covered service under the nominal fee.

***Patients are required to pay the full cost of labs and appliances (supplies) for dentures, crowns, bridges, etc. based on PHS actual cost.*

Patient must sign below stating they have read the Community Dental Sliding Fee Scale Disclaimer.

Patient Signature:_____ Date:_____

Community Dental
1102 S Virginia Street, Suite B- Hopkinsville, KY 42240
270-632-3088 (Phone) - 270-632-8212 (Fax)

Sliding Fee Discount Application
ATTACHMENT B

The Sliding Fee Discount Program is designed to provide discounted services to patients who have limited or no means to pay for their medical services. The slide program's intent is to assure that no patient will be denied services due to an individual's inability to pay for services. Discounts will be based on household income and size.

Sliding Fee Discount Program applications cover patient balances incurred within 12 months after the approved application date. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in household size or income.

Please complete Sliding Fee Discount Application entirely. Sign and return the completed application and proof of income information to the health center within 14 days of the initial visit. Discount will start on the day the proof of income is received.

The discount will apply to all in-house services received at this clinic. Outside services will not be included in the health centers Slide Fee Discount Program. Additional discounts may apply for these services as indicated in the Slide Fee Schedule.

This form must be completed every 12 months or if your financial situation changes.

Patient ID#

_____

Patient's Name:

_____

Social Security Number:

_____

Total Number of Household Members:	**Total Household Income:**
_____	_____ ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly**

NOTE: Proof of Income information is required before discount qualification can be processed.

I certify that the household size and income information shown above is correct. I understand that Outreach Specialist may use my application information and income verification to help me with additional medical and social needs, as needed.

Name (Print) _____

Signature _____ **Date** _____

NAME OF HEAD OF HOUSEHOLD			**Date of Birth**	
STREET	**CITY**	**STATE**	**ZIP**	**PHONE**
Employed Yes or No	**Company Name/Source of Income**	**Income Before Taxes**	☐ Wkly ☐ Bi-Wkly ☐ Mthly ☐ Bi-Mthly ☐ Annually	**Primary Insurance Name**
Dependents			**Date of Birth**	
Employed Yes or No	**Company Name/Source of Income**	**Income Before Taxes**	☐ Wkly ☐ Bi-Wkly ☐ Mthly ☐ Bi-Mthly ☐ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed Yes or No	**Company Name/Source of Income**	**Income Before Taxes**	☐ Wkly ☐ Bi-Wkly ☐ Mthly ☐ Bi-Mthly ☐ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed Yes or No	**Company Name/Source of Income**	**Income Before Taxes**	☐ Wkly ☐ Bi-Wkly ☐ Mthly ☐ Bi-Mthly ☐ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed Yes or No	**Company Name/Source of Income**	**Income Before Taxes**	☐ Wkly ☐ Bi-Wkly ☐ Mthly ☐ Bi-Mthly ☐ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed Yes or No	**Company Name/Source of Income**	**Income Before Taxes**	☐ Wkly ☐ Bi-Wkly ☐ Mthly ☐ Bi-Mthly ☐ Annually	**Primary Insurance Name**

Dependent			**Date of Birth**	
Employed ◯ **Yes or No** ◯	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**
Dependent			**Date of Birth**	
Employed **Yes or No**	**Company Name/Source of Income**	**Income Before Taxes**	□ Wkly □ Bi-Wkly □ Mthly □ Bi-Mthly □ Annually	**Primary Insurance Name**

Office Use Only

Income	Amount	Rate	Total Income
		<u>Annual</u> <u>Monthly Rate</u> X 52 Wkly X 4 Wkly X 24 Bi- Mthly X 2 Bi-Wkly X 26 Bi-Wkly X 12 Mthly X 1 Annual	
		<u>Annual</u> <u>Monthly Rate</u> X 52 Wkly X 4 Wkly X 24 Bi- Mthly X 2 Bi-Wkly X 26 Bi-Wkly X 12 Mthly X 1 Annual	
		<u>Annual</u> <u>Monthly Rate</u> X 52 Wkly X 4 Wkly X 24 Bi- Mthly X 2 Bi-Wkly X 26 Bi-Wkly X 12 Mthly X 1 Annual	
		Total Household Income	

Discount applied to patients:

_____________________________ _____________________________ _____________________________
_____________________________ _____________________________ _____________________________
_____________________________ _____________________________ _____________________________

Alternative Payment Source (Medicare/Medicaid) applied for? Yes No Refused

Income verified by proof of income? Yes No

Approved Discount Class Assigned: ____________________

Approved by: __________________ ______ Date Approved/Effective: ______________

Slide Insurance Setup: Yes No Slide Card Mailed: Yes No