KEYSTONE RURAL HEALTH CONSORTIA, INC.

MEDICAL/BH_____

Sliding Fee Discount Eligibility Form

DENTAL_____

DATE

IT IS NECESSARY FOR US TO ASK PERSONAL QUESTIONS IN ORDER TO GIVE YOU A DISCOUNT ON OUR FEES AND PHARMACEUTICALS. THIS INFORMATION WILL BE KEPT ON FILE IN OUR CENTER IN STRICT CONFIDENCE. YOU MUST VEIFY YOUR INCOME ANNUALLY IN ORDER TO REMAIN ELIGIBLE FOR OUR SLIDING FEE. YOUR ANNUAL GROSS INCOME AND HOUSEHOLD SIZE WILL BE USED TO CALUCULAT THE LEVEL OF YOUR PAYMENT.

NAME

ADDRESS

CITY **STATE** **ZIP**

TELEPHONE NUMBER **CELL NUMBER**

SOCIAL SECURITY NUMBER

TOTAL HOUSEHOLD MEMBERS

DATE OF BIRTH

HOUSEHOLD MEMBERS CONSIST OF ANY PERSON RESIDING IN THE HOME THAT IS A DEPENDENT OF THE APPLICANT

GIVE NAMES, DATE OF BIRTH, AND SOCIAL SECURITY NUMBERS OF ALL MEMBERS LIVING IN THE HOUSEHOLD:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

DO YOU RECEIVE ANY INCOME FROM ANY OF THE FOLLOWING SOURCES, IF SO, HOW MUCH?

SOURCE	YOU	YOUR SPOUSE	YOUR CHILDREN	OTHER PERSON	TOTAL
WAGES/SALARIES/TIPS					
SOCIAL SECURITY BENEFITS					
NET SELF EMPLOYMENT					
UNEMPLOYMENT BENEFITS					
RETIREMENT AND PENSION					
INVESTMENT/RENTAL INCOME					

YOU MUST PROVIDE DOCUMENTATION TO VERIFY THE ABOVE INCOME.
ACCEPTABE FORMS OF DOCUMENTATION INCLUDE:
*****MOST CURRENT 3 PAYSTUBS*
*****LETTER FROM EMPLOYER*
*****MOST CURRENT 2 BANK STATEMENTS*
*****MOST CURRENT FEDERAL INCOME TAX RETURN*
*****BENEFIT AWARD LETTERS*

KEYSTONE RURAL HEALTH CONSORTIA, INC.

Medical/BH ____

Sliding Fee Discount Eligibility Form

Dental ____

I understand payment is expected at each visit for all KRHC services.

I understand that at the time of service I will be required to pay the DETERMINED CHARGE on the Declaration of Income and Sliding Fee Application or the actual charge, whichever is less. Lesser fees may apply if the nominal fee is less than the standard fee.

I understand that I will be billed for any outstanding balances and it is my obligation to make payment in full or payment arrangements prior to my next scheduled visit or I may be rescheduled.

I agree the information provided on this application is true and correct to the best of my knowledge. I agree that any misleading information or omissions may disqualify me from further consideration for the sliding fee program. I understand that I am requesting a discount for services provided by Keystone Rural Health Consortia, Inc. If I am granted a discount I understand I must comply with any and all requirements of the Sliding Fee Discount Program and meet my financial obligations at each visit. I agree to notify Keystone Rural Health Consortia if any income information provided in this application changes before the annual renewal date.

SIGNATURE **DATE**

APPROVED DETERMINED CHARGE AMOUNT

MEDICAL/BH	DENTAL Preventive, Diagnostic & Low Restorative	DENTAL High Restorative	DENTAL Lab Services
A $5	**A** $10	**A** $10	**A** $150 to $300
B $35	**B** 25% of KRHC Fee	**B** 25% of KRHC Fee	**B** 65% of KRHC Fee
C $50	**C** 40 % of KRHC Fee	**C** 40% of KRHC Fee	**C** 70% of KRHC Fee
D $65	**D** 60% of KRHC Fee	**D** 60% of KRHC Fee	**D** 75% of KRHC Fee
FULL CHARGE	**FULL CHARGE**	**FULL CHARGE**	**FULL CHARGE**

APPROVED BY **DATE**

2020 Keystone Rural Health Consortia, Inc. Sliding Fee Table

MEDICAL & BEHAVIORAL HEALTH SLIDING FEE TABLE

Family Size	A Nominal Fee $5	B $35	C $50	D $65
Poverty Level	100% and Below	101%-133%	134%-167%	168%-200%
1	12,760	16,971	21,309	25,520
2	17,240	22,929	28,791	34,480
3	21,720	28,888	36,272	43,440
4	26,200	34,846	43,754	52,400
5	30,680	40,804	51,236	61,360
6	35,160	46,763	58,717	70,320
7	39,640	52,721	66,199	79,280
8	44,120	58,680	73,680	88,240

DENTAL Preventive, Diagnostic

Family Size	A Nominal Fee $10	B 25% of KRHC Fees	C 40% of KRHC Fees	*D* 60% of KRHC Fee
Poverty Level	100% and Below	101%-133%	134%-167%	168%-200%
1	12,760	16,971	21,309	25,520
2	17,240	22,929	28,791	34,480
3	21,720	28,888	36,272	43,440
4	26,200	34,846	43,754	52,400
5	30,680	40,804	51,236	61,360
6	35,160	46,763	58,717	70,320
7	39,640	52,721	66,199	79,280
8	44,120	58,680	73,680	88,240

DENTAL Low Restorative/Treatment

Family Size	A Nominal Fee $10	B 25% of KRHC Fee	C 40% of KRHC Fee	D 60% of KRHC Fee
Poverty Level	100% and Below	101%-133%	134%-167%	168%-200%
1	12,760	16,971	21,309	25,520
2	17,240	22,929	28,791	34,480
3	21,720	28,888	36,272	43,440
4	26,200	34,846	43,754	52,400
5	30,680	40,804	51,236	61,360
6	35,160	46,763	58,717	70,320
7	39,640	52,721	66,199	79,280
8	44,120	58,680	73,680	88,240

** Lesser fees apply if the nominal fee is less than the standard fee**

2020 Keystone Rural Health Consortia, Inc. Sliding Fee Table

High Restorative/Treatment

Family Size	A Nominal Fee $10	B 25% of KRHC Fee	C 40% of KRHC Fee	D 60% of KRHC Fee
Poverty Level	100% and Below	101%-133%	134%-167%	168%-200%
1	12,760	16,971	21,309	25,520
2	17,240	22,929	28,791	34,480
3	21,720	28,888	36,272	43,440
4	26,200	34,846	43,754	52,400
5	30.680	40,804	51,236	61,360
6	35,160	46,763	58,717	70,320
7	39,640	52,721	66,199	79,280
8	44,120	58,680	73,680	88,240

Lab Services

Family Size	A Nominal Fee $150-$300	B 65% of KRHC Fee	C 70% of KRHC Fee	D 75% of KRHC Fee
Poverty Level	100% and Below	101%-133%	134%-167%	168%-200%
1	12,760	16,971	21,309	25,520
2	17,240	22,929	28,791	34,480
3	21,720	28,888	36,272	43,440
4	26,200	34,846	43,754	52,400
5	30,680	40,804	51,236	61,360
6	35,160	46,763	58,717	70,320
7	39,640	52,721	66,199	79,280
8	44,120	58,680	73,680	88,240

In reference to the above tables the income ceiling for minimum fee pay class is equal to the federal poverty level. Nominal Charge is $5 for medical services and $10 for dental preventive, diagnostic and restorative services. The 2020 federal poverty level guideline increases by $4,480 for each additional family member above 8.

** **Lesser fees apply if the nominal fee is less than the standard fee****

REV 3/31/2020