



KEYSTONE RURAL HEALTH CONSORTIA, INC.
Sliding Fee Discount Eligibility Form

MEDICAL/BH _____
 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 VERIFY YOUR INCOME ANNUALLY IN ORDER TO REMAIN ELIGIBLE FOR OUR SLIDING FEE. YOUR ANNUAL GROSS INCOME AND HOUSEHOLD SIZE WILL BE USED TO CALCULATE 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. ACCEPTABLE 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.
Sliding Fee Discount Eligibility Form

Medical/BH _____

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 \$35 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

2021 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	12,880	17,130	21,510	25,760
2	17,420	23,169	29,091	34,840
3	21,960	29,207	36,673	43,920
4	26,500	35,245	44,255	53,000
5	31,040	41,283	51,837	62,080
6	35,580	47,321	59,419	71,160
7	40,120	53,360	67,000	80,240
8	44,660	59,398	74,582	89,320

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	12,880	17,130	21,510	25,760
2	17,420	23,169	29,091	34,840
3	21,960	29,207	36,673	43,920
4	26,500	35,245	44,255	53,000
5	31,040	41,283	51,837	62,080
6	35,580	47,321	59,419	71,160
7	40,120	53,360	67,000	80,240
8	44,660	59,398	74,582	89,320

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	12,880	17,130	21,510	25,760
2	17,420	23,169	29,091	34,840
3	21,960	29,207	36,673	43,920
4	26,500	35,245	44,255	53,000
5	31,040	41,283	51,837	62,080
6	35,580	47,321	59,419	71,160
7	40,120	53,360	67,000	80,240
8	44,660	59,398	74,582	89,320

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

2021 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	12,880	17,130	21,510	25,760
2	17,420	23,169	29,091	34,840
3	21,960	29,207	36,673	43,920
4	26,500	35,245	44,255	53,000
5	31,040	41,283	51,837	62,080
6	35,580	47,321	59,419	71,160
7	40,120	53,360	67,000	80,240
8	44,660	59,398	74,582	89,320

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	12,880	17,130	21,510	25,760
2	17,420	23,169	29,091	34,840
3	21,960	29,207	36,673	43,920
4	26,500	35,245	44,255	53,000
5	31,040	41,283	51,837	62,080
6	35,580	47,321	59,419	71,160
7	40,120	53,360	67,000	80,240
8	44,660	59,398	74,582	89,320

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 2021 federal poverty level guideline increases by \$4,540 for each additional family member above 8.

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