gracepoint®
THE SOURCE FOR WELLNESS

SLIDING FEE APPLICATION

The Sliding Fee Scale is a method for providing reduced fees, based on a household's size and income. In order to be eligible for this program, the following application must be completed, signed & dated with **proof of income (see listing for acceptable forms of income)** and approved.

Head of household: Last_____ First_____ Phone _____

Mailing address: _____ City_____ State_____ Zip_____

Have you or any of your household members applied for Medicaid (Title XIX)? Yes ◯ No ◯

SOURCES OF INCOME: All members living in the household. "Household" is considered tax filer + spouse + tax dependents. Please refer to chart for more information. **If your living situation is temporary, please advise the financial screener.**

Source	Amount ($)	Weekly	Bi-Weekly	Monthly	Annually	Annual Income
Salaries and Wages (self)		☐	☐	☐	☐	
Salaries and Wages (spouse)		☐	☐	☐	☐	
Salaries and Wages (other)		☐	☐	☐	☐	
Unemployment Compensation		☐	☐	☐	☐	
Social Security (Self/Spouse)		☐	☐	☐	☐	
Social Security (Children)		☐	☐	☐	☐	
SSDI (Social Security Disability Income)		☐	☐	☐	☐	
Alimony		☐	☐	☐	☐	
Military / Veterans Benefits		☐	☐	☐	☐	
Unemployment Benefits		☐	☐	☐	☐	
Rental/Investment Income		☐	☐	☐	☐	
Capital Gains Income		☐	☐	☐	☐	
Other Family Members		☐	☐	☐	☐	

HOUSEHOLD SIZE: List all household members by NAME, DATE OF BIRTH, AND SS#, include yourself:

NAME	DATE of BIRTH	RELATIONSHIP	SOCIAL SECURITY #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE READ THE FOLLOWING CAREFULLY

I declare that my household's financial status is as listed above. I understand the following:

- Gracepoint is utilizing federal tax dollars to assist me in receiving health care
- Giving false information regarding my household income is considered fraud against the U.S. government
- Any change in my finances or the number of people in my household must be reported to Gracepoint and a new application must be completed

Applicant's Signature _____Date _____

Check and sign only if applicable: ☐ I have been informed of and understand the possible financial benefits of participating in the sliding fee scale process; however at this time I do not wish to participate.

Patient Signature _____Date _____

Patient Name: _____ ID #: _____

You are required to provide proof of listed income in order to complete your application. The following are acceptable forms of income:

- Current Federal Income Tax (1040, 1040A or1040 EZ Form)
- Paystubs for recent month
- Current bank statement showing direct deposit or most recent check stubs totally one month payment (SS, SSI, SSD, Retirement accounts and/or payments, Alimony, etc.)
- Printout from office issuing payments (SS, SSDI, unemployment, VA, etc.)
- Employer statement for cash wages (must include employer name, address and phone number)
- Award letter

Front Office Use Only:

Attesting patient declined to sign application: Staff Signature: _____ Date: _____

Guarantor #: _____

Application Received/Entered: Date: _____ By: _____

Self-Reported Household Size: _____

Self-Reported Household Income: $_____

Sliding Fee Scale Level Pre-Approved: Nominal A B C D Full Fee

90 Day Waiver Eligibility:
Does the patient report one or more of the following: □ Yes □ No

- Homeless
- Recent loss of income
- Resides in Public Housing
- Filed for Bankruptcy
- Other income issue reported: _____

Patient is required to bring in written proof of homelessness, income loss, public housing, bankruptcy, etc.

Staff with the Billing Manager and/or Executive Director for approval after receiving written proof.
Set the Financial Investigation income at $0 (unless other amount is reported).

Examples of written proof:

- Homeless (Letter on letterhead from a local shelter or community provider attesting homelessness)
- Recent loss of income (Letter on employer letterhead or Unemployment Letter of Determination)
- Resides in Public Housing (Housing Lease or recent utility statement in person's name)
- Filed for Bankruptcy (County Court Filing form)

Finance Office Only:

Sliding Fee Scale Level Approved: Nominal A B C D Full Fee

Patient Notified of SFS Amount: Date: _____

□ At office/in person □ Reached patient by phone □ Attempted by phone /unable to reach patient

Revised: 10/2/2020

Patient Name: _____ ID #: _____