El Dorado Community Health Centers

Placerville Location	Cameron Park Location	Cameron Park 2 Medical/Dental
4212 Missouri Flat Road	3104 Ponte Morino Dr, Ste. 110	3100 Ponte Morino Dr, Ste. 120
Placerville, CA 95667	Cameron Park, CA 95682	Cameron Park, CA 95682

SLIDING FEE DISCOUNT PROGRAM

Background of Sliding Fee Discount Program

The Sliding Fee Discount Program is a Federal program that permits the El Dorado Community Health Centers to discount normal charges for medical, behavioral health and dental service visits. According to law, it requires two pieces of information to qualify: the amount of money earned in the household and the number of people who live in the household. In order to be eligible for the Sliding Fee Scale, you must provide accurate and acceptable proof of income as well as list all persons within the household. **Only appointments seen within 10 business days prior to submitting the application will be covered under the SFDP otherwise you will be responsible for 100% of all charges.** You must report any changes in family income or number of members in the household when these changes occur. **Falsification of this information will result in forfeiture of Sliding Fee Discount privileges.**

Note: Sliding Fee Discount Program is NOT AN INSURANCE PRODUCT. This is a discount on cash pay services provided within our centers only.

Eligibility

All patients are eligible to apply for the sliding fee discount program. Determination of the discount, if any, is dependent upon household income and household size in comparison to the current Federal Poverty Level guidelines (FPL).

Term

Information must be updated every 12 months or with any change of household income or household size.

Definitions and Examples of Acceptable Proof Required:

Income Determination

1. **Income is based on the gross income of all household members earning income.**

Income used to compute poverty status:

a. 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, assistance from outside the household, and other miscellaneous sources.

2. **Acceptable forms of proof for determining income include the following (CHOOSE ONE)**

a. Income Tax Return: A signed copy of the most recent tax return showing Adjusted Gross Income.
b. Paycheck stubs: Two or more pay stubs indicating gross pay within the past thirty (30) days.
c. Agency letter: A letter from the Social Security Administration, Veterans Administration or Social Service Agency (Public Assistance) indicating income level.
d. Unemployment Verification: Paperwork from the Employment Securities Commission (ESC) proving unemployment status and the amount of unemployment compensation being received.
e. Court Documents: Official documents citing alimony as awarded by a judge.
f. Official Paperwork: Paperwork documenting retirement, disability, SSI benefits.
g. Employer Letter: For those not receiving an actual paycheck, a letter from the patient's employer detailing current gross income and frequency of pay periods may be accepted. Contact information must be provided so that information can be verified.
h. Bank Statements: Three (3) prior months of bank statements.
I. If you are unemployed, and/or do not have a source of income, please complete the Declaration of Facts and explain your current situation.

Household Size Determination

1. **The following documentation can be used to support your household size and financial resource pooling:**

a. A copy of the most recent tax return showing household size.
b. Court or government documents that indicate the number of members in household.
c. Declaration of Facts sheet.

Sliding Fee Discount Application-Eligibility Statement

Patient Information	**Applying for discount services: Medical ☐ Dental ☐ Both Medical/Dental ☐**			
First Name:	Middle:	Last:	Other Names Used:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	Do you have health insurance? (circle one) **YES** or **NO** Insurance Company:		
Date of Birth: / /	Social Security # - -	Do you have dental insurance? (Circle one) **YES** or **NO** Insurance Company:		
Relationship Status:	Single Married Separated Divorced Widowed Other:_____			

Household Size (persons you support financially) Include additional household members on the back of this page if needed. Name:	**Date of Birth**	**Social Security #**	**Is this person applying for the Sliding Fee Discount Program? (Circle one)**	**Does this person have health/dental insurance? (Circle one)**
1. Spouse/Partner:			**Yes No** Name:_____	**Yes No** Name:_____
2. Dependent:			**Yes No** Name:_____	**Yes No** Name:_____
3. Dependent:			**Yes No** Name:_____	**Yes No** Name:_____
4. Dependent:			**Yes No** Name:_____	**Yes No** Name:_____

NOTE: To comply with federal regulations, in order to grant you discounted medical services, it is necessary to ask for personal information. Your information will be kept confidential. You must verify your income every 12 months.

Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Household Income

Name	**Amount**	**Frequency (Circle one)**	**Employer:**
1. Applicant	$	Weekly Bi-weekly Monthly Yearly	
2. Spouse/Partner	$	Weekly Bi-weekly Monthly Yearly	
3. Children	$	Weekly Bi-weekly Monthly Yearly	
4. Other	$	Weekly Bi-weekly Monthly Yearly	
5. Other	$	Weekly Bi-weekly Monthly Yearly	
TOTAL	$	Weekly Bi-weekly Monthly Yearly	

Other Income	**Applicant**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement/Pension					
Food Stamps					
Alimony					
Interest Income					
Other					
				TOTAL	**$**

I understand that the information I provide on this form is subject to verification by EDCHC. I certify that the above information is true and correct to the best of my knowledge and that I understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.

Name(Print): _____ _____

Name of Applicant Name of Spouse/Partner

Signature: _____ Signature: _____ Date: ____/____/____

El Dorado Community Health Centers
(530) 621-7700 FAX: (530) 621-7713

Sliding Fee Discount Program- Eligibility

Date: _____/_____/_____
Name: _____
Patient I.D. #:_____

Declaration of Fact

I, _____, _____; present the following information as
(First name) (Last name)
my sworn statement of fact(s). I submit this statement because I am unavailable to provide the required verification(s) of income(s) at this time. If you do not receive any income, please explain your means of support. Example: How are you paying for food, rent, or other bills?

I declare (under penalty of perjury) the following (please explain your current situation):

_____
_____
_____
_____
_____
_____
_____

Household size includes:

Name	Date of Birth	Relationship
Self:		
Spouse/Partner:		
Dependent:		
Dependent:		
Dependent:		
Dependent:		
Dependent:		
Dependent:		

Any person who signs this statement and who willfully states as true any material matter which he knows to be false is subject to the penalties prescribed for perjury *(see Penal Code by the State of California 11054 of the W&I Code).*
I declare under penalty of perjury that the statement made herein is true and correct to the best of my knowledge. I am aware it is unlawful to provide false information.

Signature of Applicant	Date	Signature of Spouse/Partner	Date