SLIDING FEE DISCOUNT PROGRAM

neighborcare health

Neighborcare Health's Sliding Fee Discount Program follows federal guidelines based on family size and income. **Patients need to:**

- Make an appointment with an eligibility specialist to complete an application for a health insurance program.
- Provide information regarding family size, household income, and identity information.

Applications and printed copies of supporting documents must be given directly to an eligibility specialist. They cannot be mailed or faxed, stored or dropped off at the clinic front desk.

FAMILY SIZE AND HOUSEHOLD INCOME DOCUMENTATION:

- ❑ **Current 1040 Federal Tax Form** (provide birth and/or marriage certificates if dependents are not listed on the tax return).
- ❑ **Taxable earned gross income** (ex., pay stubs/wages and tips/gratuities, back pay, bonuses, military pay, self-employment, hobby income, compensation for personal services, etc.) and unearned income (ex., income from interest, dividends, capital gains, pension, rent, royalties and foreign income, unemployment, alimony, IRA distributions, income from interest, annuities, etc.), for the past 30 days (for every working member in household).
- ❑ **Other pertinent documentation:**
  - ❑ Employer letter stating your gross monthly income (for the last 30 days).
  - ❑ Last **two** unemployment check stubs (if receiving unemployment).
  - ❑ A letter of support, or reference from an organization/individual, and a signed statement of zero income.

IDENTITY VERIFICATION:

- ❑ A current photo ID such as driver's license, state-issued identification card, military ID, etc.

Please provide the information listed above (or any other documentation needed by Neighborcare Health, on a case by case basis.) within forty-five (45) days of today's visit or pay the full amount for today's charges.

- ❑ ***I choose not to provide income information and understand that I will be responsible for full payment of services rendered.***

LIST YOURSELF AND ALL THE DEPENDENTS IN YOUR HOUSEHOLD:

Name:		DOB:		Name:		DOB:	
Name:		DOB:		Name:		DOB:	
Name:		DOB:		Name:		DOB:	

IF INSURED, PLEASE PROVIDE THE PERTINENT HEALTH INSURANCE INFORMATION:

Insurance Name:		Subscriber Name/ Patient Name:		
Policy Number:		Group Number:		
Insurance Phone:		Work Phone:		
Relationship to subscriber:		Subscriber's DOB:	/ /	(sex) ❑ M ❑ F

I understand the above information and agree that I will provide the information needed to verify my family size, household income, and my personal identity. I understand that if I do not provide this information within forty-five (45) days of today's visit, I will be billed at full fee. I agree to pay all costs not covered by my insurance carrier.

Neighborcare Health's Sliding Fee Program does not cover immunizations, co-payments (including co-payments associated with managed care plans), deductibles, high cost contraceptives (e.g. IUDs) and OB services. If you are pregnant, please schedule an appointment with eligibility to determine if you qualify for either state-sponsored insurance or Medicaid. If you do not qualify, you will be asked to sign a Prenatal Agreement and set up a payment plan. Please contact a Patient Account Specialist (206-548-3100) for more information.

Signature		Date Requested:			Date Verified:		
Print Name of Patient		Expiration Date:			MRN/ Account #:		
Main Phone		Family Size:		Yearly Income:		Scale:	
Personal Email		Entered in system by:				Date:	

*** ALL INFORMATION NEEDS TO BE UPDATED ANNUALLY/UPON REQUEST *** TOP COPY TO CLINIC | BOTTOM COPY TO PATIENT | PAD-104 – SLIDING FEE APPLICATION – REV. **06-2021**