Central Florida Health Care
Health Care With a Heart

Sliding Fee Scale Application

To qualify for the above listed program, you must provide documentation of the income for ALL members of the household who are 18 years and older as listed below:

It is the policy of Central Florida Health Care, Inc. (CFHC) to provide services defined within the scope of project regardless of the patient's ability to pay. Discounts are offered based on household size and income. The discount will apply to services received at our facility but will not cover those supplies purchased outside of the health center. Discounts apply for 365 days from the date of approval and will be re-assessed every 365 days after that. CFHC will reassess the patient's income levels any time there is a change in their pay status throughout the year.

List Household Members Below:

A household is defined as a group of two or more people related by birth, marriage, or adoption who live together.

#	NAME	DATE OF BIRTH	AGE	RELATIONSHIP
1				
2				
3				
4				
5				
6				
7				
8				

As a Community Health Center, federal regulations require CFHC to obtain proof of income for our records. Proof of Income includes income from ALL sources for ALL adults listed above. Sources of income include, but are not limited to gross wages, tips, social security, disability, pensions, annuities, veteran's payments, self-employment income, alimony, child support, military, unemployment public aid, and any other sources of income excluding non-cash benefits. Below is a list of acceptable documentation of income.

OPTION A

PROVIDE 1 DOCUMENT LISTED BELOW

CHECK ALL THAT APPLY

- ☐ Paystubs (1 most recent full month)
- ☐ Bank Statements (3 most recent full months)
- ☐ Tax Returns (current tax year)
  - ☐ previous tax year requires copy of extension request
- ☐ W2 (current tax year only)
- ☐ Employment Verification Letter

IF NONE APPLY, UTILIZE OPTION B.
IF HOUSEHOLD INCLUDES STUDENT OR MEMBER WITH NO INCOME, UTILIZE OPTION C IN CONJUNCTION WITH A OR B.

OPTION B

PROVIDE 1 DOCUMENT LISTED BELOW *AND*
BANK STATEMENTS (3 MOST RECENT FULL MONTHS)

CHECK ALL THAT APPLY

- ☐ SSA/SSI Award Letter
- ☐ Veteran Benefits
- ☐ Pension/Annuities
- ☐ Estate/Trusts
- ☐ Worker's Compensation
- ☐ Unemployment Assistance Award Letter
- ☐ Child Support/Alimony
- ☐ Rental Income
- ☐ Dividends and Interest in Savings/Stocks/Bonds

OPTION C

SPECIAL CIRCUMSTANCES ONLY AND TO BE USED WITH OPTIONS A OR B

CHECK ALL THAT APPLY

- ☐ 18 years or older STUDENTS – 1 of the following are required:
  - ☐ current year class schedule from school
  - ☐ student ID with current school year listed
  - ☐ letter from school stating student status with school letterhead
- ☐ 18 years or older Household Member stating no income:
  - ☐ Affidavit of Support
  - ☐ Bank Statements (3 most recent full months)

I certify that the Household listed above, and my attached Proof of Income accurately depicts my household size and income.

_____ _____

Head of Household Signature **Date of Application**

CFHC's Billing Department reserves the right to request additional information for final review and approval.
Falsification or misrepresentation of your application may result in denial of program benefits.

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Sliding Fee Scale Discount Acknowledgement Form

Based on the information provided, a member of our CFHC team has preliminarily determined that your Sliding Fee Discount Classification is one of the following:

	Nominal Fees for Services Listed					
Discounted Charge Classification	Medical GYN Behavioral Health Optical	Dental OB Other Specialists	Lab	Radiology	Nutrition/ Dietician	**Income Criteria**
Slide A: **0%**	$25.00	$50.00	$25.00	$15.00	$5.00	At or below 100%
Slide B: **25%**	$25.00	$50.00	$25.00	$15.00	$5.00	At 101-150%
Slide C: **50%**	$25.00	$50.00	$25.00	$15.00	$5.00	At 151-175%
Slide D: **75%**	$25.00	$50.00	$25.00	$15.00	$5.00	At 175-200%
Slide E: **100%**	100%	100%	100%	100%	100%	At or above 201%

A financial assessment is required to determine what discount you and your family may qualify for based on your household size and income. If you do not have the necessary information available, you will have 30 days from the start of your application to provide additional documentation of income to be considered for the SFS program. If documentation is not received within 30 days, you will be responsible for 100% for all charges incurred from the date of this application until such documentation is provided.

Nominal fees are a single amount per visit expected to be paid when you check in for your appointment after qualifying for Slide A: 0%. Slides B, C, and D have a nominal fee and a percentage of visit that is expected to be paid at time of check-in. Please see the examples below of your patient responsibility after qualifying for the SFS program:

Slide A: nominal fee for rendered service

Slide B: nominal fee for rendered service + 25% of total cost of visit

Slide C: nominal fee for rendered service + 50% of total cost of visit

Slide D: nominal fee for rendered service + 75% of total cost of visit

Slide E: 100% of total cost of visit

Additional charges may apply to other services and equipment (i.e. dental prosthetics, glasses, frames, Pharmacy EPPAP, etc.)

I hereby acknowledge that the Sliding Fee Scale Discount Program has been explained to me, including the charges and terms of payments. I agree with the classification that I am assigned. I also understand the CFHC Billing Department will be reviewing all documentation provided and confirming my eligibility. I understand that falsification or misrepresentation of my application may result in denial of program benefits.

_____ _____

Head of Household Signature **Date of Application**

Expected expiration date of the discount program and the classification I have been assigned is one year (365 days) from the date of this application.

Central Florida Health Care, Inc. (CFHC) is an Equal Opportunity Employer. CFHC, Inc. does not provide preferential treatment to any one patient. CFHC, Inc. provides preventative and primary medical, dental, vision, specialty, behavioral health, and nutritional services to eligible patients regardless of their ability to pay. Every patient has the right to seek services at CFHC, Inc. free from all forms of discrimination. All patients will be treated without regard to age, sex, color, religion, race, national origin, citizenship, veteran status, current or future military or familial status, sexual orientation, gender identification, martial status, physical or mental disability, legal source of income or any other status protected by laws.