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 VEIFY YOUR INCOME ANNUALLY IN ORDER TO REMAIN ELIGIBLE FOR OUR SLIDING FEE. YOUR ANNUAL GROSS INCOME AND HOUSEHOLD SIZE WILL BE USED TO CALUCULAT THE LEVEL OF YOUR PAYMENT.

NAME ____________

ADDRESS ____________

CITY ____________ **STATE** ____________ **ZIP** ____________

TELEPHONE NUMBER ____________ **CELL NUMBER** ____________

SOCIAL SECURITY NUMBER ____________

DATE OF BIRTH ____________

TOTAL HOUSEHOLD MEMBERS ____________

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. ACCEPTABE FORMS OF DOCUMENTATION INCLUDE:

*****MOST CURRENT 3 PAYSTUBS*

*****LETTER FROM EMPLOYER*

*****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**

2023 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	14580	19391	24349	29160
2	19720	26228	32932	39440
3	24860	33064	41516	49720
4	30000	39900	50100	60000
5	35140	46736	58684	70280
6	40280	53572	67268	80560
7	45420	60409	75851	90840
8	50560	67245	84435	101120

DENTAL Preventive, Diagnostic, Low Restorative, High Restorative

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	14580	19391	24349	29160
2	19720	26228	32932	39440
3	24860	33064	41516	49720
4	30000	39900	50100	60000
5	35140	46736	58684	70280
6	40280	53572	67268	80560
7	45420	60409	75851	90840
8	50560	67245	84435	101120

DENTAL Lab Services

Family Size	A Nominal Fee $35-$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	14580	19391	24349	29160
2	19720	26228	32932	39440
3	24860	33064	41516	49720
4	30000	39900	50100	60000
5	35140	46736	58684	70280
6	40280	53572	67268	80560
7	45420	60409	75851	90840
8	50560	67245	84435	101120

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 2023 federal poverty level guideline increases by $5140 for each additional family member above 8.

Rev 02/23