

Received Date: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Approval Date: \_\_\_\_\_\_\_\_\_\_\_\_ By\_\_\_\_\_\_\_\_\_\_\_

Applicant Name: Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Check One) Status: Discount ○ A ○ B ○ C ○ D ○ E Denied \_\_\_\_\_\_\_

Effective Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (36) months

Dear Applicant,

Genesis Health Care, Inc. invites you to apply for our Sliding Fee Discount Program. We are dedicated to providing quality health care at affordable prices to residents of our community. Eligibility for the program is based on several factors, including your annual household income and the number of persons living in the household. Please fill out the attached paperwork in full and return it to us with the necessary documentation.

Complete applications will be processed, and a letter with your discount determination will be mailed to you. If your application is denied, we will mail you a letter with an explanation of denial.

Missing information or incomplete applications will place the application on hold until we receive all necessary information. If you have any questions, please feel free to call (843) 393-7452 during normal business hours and ask for our Financial Coordinator.

Thank you for your cooperation in turning in a complete application so that we may help you obtain financial assistance for your medical services here at Genesis Health Care.

Sincerely,

Genesis Health Care, Inc.

Sliding Fee Scale Application

**To comply with federal regulations and offer you a discount on our medical services, it is necessary to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year along with your household size. Proof of acceptable income is as follow: Your yearly income tax return (must be completed), copy of your last month’s paycheck stubs, or if neither is available you may sign the Patient Financial Self-Attestation Agreement.**

First Name: Middle: Last: Other names:

Home Address: City: State: Zip:

Phone #: Social Security #:

Date of Birth: Marital Status: □ Single □ Married □ Divorced □ Separated

 □ Widowed □ In a Relationship

Do you consider yourself homeless? Have you applied for medical assistance?

 □ yes □ no □ yes □ no

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Household Members** | **Name** | **Date of Birth Month/Day/Year** | **Social Security Number** | **Health Insurance** | **Relationship** | **Patient at GHC?** |
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|  |  |  |  |  |  |
| **Income** | **Monthly/Annual Income** | **For YOU** | **For SPOUSE** | **For Children** | **For Other** | **Subtotal** |
| Gross wages, salaries, and tips |  |  |  |  |  |
| Social security & pensions |  |  |  |  |  |
| Annuity & veteran benefits |  |  |  |  |  |
| Child support & alimony |  |  |  |  |  |
| Self employment & Other |  |  |  |  |  |
|  |  |  |  | TOTAL |  |

***Patient Financial Self-Attestation Agreement***

***I understand that Genesis Health Care, Inc. will use the information that I have provided to determine my financial eligibility for federally subsidized health care. I further attest that the information that I have provided to Genesis Health Care, Inc. is true and correct.***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ L.S.***

***Patient signature***

*GHC STAFF USE ONLY:*

Qualification Determination:

\_\_\_\_\_ **The applicant qualifies for the Sliding Fee Discount Program and will be classified as follows:**

 \_\_\_\_\_ Level A : $15.00 minimum each visit

 \_\_\_\_\_ Level B : 15% of charge or 15% of patient allowable from insurance company

 \_\_\_\_\_ Level C : 30% of charge or 30% of patient allowable from insurance company

 \_\_\_\_\_ Level D : 50% of charge or 50% of patient allowable from insurance company

 \_\_\_\_\_ Level E : 70% of charge or 70% of patient allowable from insurance company

**This qualification is for a 36 month period ending : \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

Date card mailed: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

\_\_\_\_\_ **The applicant does not qualify for the Sliding Fee Discount Program at this time**

Letter of Denial Sent: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Signature of GHC Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_



Sliding Fee Scale Application

By completing and submitting this application, I certify that:

1. I am authorized to complete the above application for financial assistance under the guidelines of Genesis Health Care’s Sliding Fee Discount Program.
2. All the information provided on this application is true and correct and I have not omitted any material matters in providing the information.
3. I understand that any time there is a change in my total household income or size, I will notify Genesis Health Care, Inc. and the change will be supported by submission of appropriate documentation.
4. This application for the Sliding Fee Discount Program is valid for a maximum of thirty-six (36) months from the date of approval. However, I understand that my income and household size will be verified annually.
5. I am at least 18 years old or have been declared by a court to be emancipated or am emancipated by marriage or other legal definition.

6. I understand and accept the fact that false information on this application will result in denial of this application, at which point I will be responsible for 100% of any medical expenses accrued at Genesis HealthCare, Inc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of GHC Staff Person Date

 Revised 09/22/2016