DATE: _____

Dear Applicant,

Genesis Health Care, Inc. invites you to apply for our Sliding Fee 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 family size of those living in the household. Please fill out the attached paperwork in full and return it to us with the necessary documentation. All information provided will be kept on file and in strict confidence.

Completed 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 to determine the appropriate discount level. To continue to qualify, you must verify family household income and size on an annual basis. If you have any questions, please feel free to call (843) 393-7452 during normal business hours and ask for a Financial Counselor.

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

Sincerely,

Genesis Health Care, Inc.

Applicant Name: Last_____ First _____ Account # _____

Sliding Fee Scale Application

Proof of acceptable income includes, but is not limited to: your yearly income tax return (must be completed), copy of your last month's paycheck stubs, current bank statement showing direct deposit, or you may sign the Patient Financial Self-Attestation Agreement.

First Name:	Middle:	Last:	
Home Address:	City:	State:	Zip:
Phone #:	Date of Birth:		
Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed			
Do you consider yourself homeless? □ yes □ no	Have you applied for medical assistance? □ yes □ no		
Do you or any family member of your household receive Medicare Extra Help or any other type of low-income subsidy? □ yes □ no			
If no, would you like assistance in applying for any extra help? □ yes □ no			

To Be Completed by Patient/Guardian for EACH family member of the household		Name	Relationship	DOB	Health Insurance	Income Verification Method	Income Frequency	Income	GHC Patient?	Account Number
	1.									
	2.									
	3.									
	4.									
	5.									
	6.									
	7.									

Total Annual Income:_____

Patient Financial Self-Attestation Agreement/Acknowledgement

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. I understand it is my responsibility to notify GHC of any changes to my income. I also understand that I must re-apply for the sliding fee program every 12 months, or sooner if my family household income changes.

Print Name: _____

Signature: _____ **Date:** _____/_____/_____

Relationship to Patient: _____

Additional Social/Other Considerations:

1. Please indicate participation in any of the following other financial assistance programs (mark all that apply):

___ Disability assistance including SSI, SSDI ___ Veteran Assistance ___ Temporary Assistance for Needy Families

___ Private Short/Long Term Disability Benefits ___ Workers Compensation ___ Water Assistance

___ Other

2. Please indicate if you are affected by any of the following ADL (activities of daily living) Difficulties (mark all that apply):

___ Eating ___ Mobility ___ Bathing ___ Toileting ___ Dressing

3. Please indicate if you suffer from any of the following Illnesses (mark all that apply):

___ ALS ___ Cancer ___ MS ___ Parkinson's ___ Morbid Obesity ___ Alzheimer's

4. Please indicate if you take any of the following medications based on a diagnosed diseased (mark all that apply):

____ Oncology Medications _____ Specialty Medication ____ A single medication with out of pocket cost exceeding $100 per month

5. Do you have difficulty paying monthly expenses and for needed medications? ___ Yes ___ No

   If yes, please explain:

6. Do you take 7 or more prescribed medications per month? ___ Yes ___ No

7. Please indicate the % of monthly/annual income contributed to the following:

   _____ Health Care Expenses (other than medications)
   _____ Student Loan
   _____ Dependent Care Expense(s)
   _____ Other

   _____ Total Monthly/Annual % of Income

Patient Financial Self-Attestation Agreement/Acknowledgement

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. I understand it is my responsibility to notify GHC of any changes to my income. I also understand that I must re-apply for the sliding fee program every 12 months, or sooner if my family household income changes.

Print Name: _____

Signature: _____ **Date:** _____/_____/_____

I attest that I have explained the application to the patient, reviewed all information provided by the patient, confirmed that all required documentation is present, answered all questions related to the application, and have determined the application has been completed in its entirety.

Signature of GHC Staff: _____ **Date:** _____/_____/____

GHC STAFF USE ONLY:

Applicant Name:

Last: _____ First: _____ Account #: _____

Qualification Determination:

2020 OFFICE VISITS

	LEVEL A 100% of FPG Nominal Fee of $15 or *$0		LEVEL B 100% - 125% FPG Pay 15% of Standard Fee		LEVEL C 125% - 150% FPG Pay 30% of Standard Fee		LEVEL D 150% - 175% FPG Pay 50% of Standard Fee		LEVEL E 175% - 200% FPG Pay 70% of Standard Fee		LEVEL F 200% - 300% FPG Pay 100% of Standard Office Visit Fee	
Family Size	**Annual Income from:**	**to:**	**Annual Income from:**	**to:**	**Annual Income from:**	**to:**	**Annual Income from:**	**to:**	**Annual Income from:**	**to:**	**Annual Income from:**	**to:**
1	**$0.00**	**$12,760**	**$12,760.01**	**$15,950**	**$15,950.01**	**$19,140**	**$19,140.01**	**$22,330**	**$22,330.01**	**$25,520**	**$25,520.01**	**$38,280**
2	**$0.00**	**$17,240**	**$17,240.01**	**$21,550**	**$21,550.01**	**$25,860**	**$25,860.01**	**$30,170**	**$30,170.01**	**$34,480**	**$34,480.01**	**$51,720**
3	**$0.00**	**$21,720**	**$21,720.01**	**$27,150**	**$27,150.01**	**$32,580**	**$32,580.01**	**$38,010**	**$38,010.01**	**$43,440**	**$43,440.01**	**$65,160**
4	**$0.00**	**$26,200**	**$26,200.01**	**$32,750**	**$32,750.01**	**$39,300**	**$39,300.01**	**$45,850**	**$45,850.01**	**$52,400**	**$52,400.01**	**$78,600**
5	**$0.00**	**$30,680**	**$30,680.01**	**$38,350**	**$38,350.01**	**$46,020**	**$46,020.01**	**$53,690**	**$53,690.01**	**$61,360**	**$61,360.01**	**$92,040**
6	**$0.00**	**$35,160**	**$35,160.01**	**$43,950**	**$43,950.01**	**$52,740**	**$52,740.01**	**$61,530**	**$61,530.01**	**$70,320**	**$70,320.01**	**$105,480**
7	**$0.00**	**$39,640**	**$39,640.01**	**$49,550**	**$49,550.01**	**$59,460**	**$59,460.01**	**$69,370**	**$69,370.01**	**$79,280**	**$79,280.01**	**$118,920**
8	**$0.00**	**$44,120**	**$44,120.01**	**$55,150**	**$55,150.01**	**$66,180**	**$66,180.01**	**$77,210**	**$77,210.01**	**$88,240**	**$88,240.01**	**$132,360**

**Based on patient's ability to pay*

Additional Data Utilization Populations (all groups below pay 100% of Standard Office Visit fee):

- **Level G – Patients at 301% of poverty or greater that meet additional social/other considerations as identified in SF Application Page 3**
- **Level H – Patients at 301% or poverty or greater with no additional social/other considerations as identified in SF Application Page 3**

For family units with more than 8 members, add for each additional member:

100% of poverty	**$4480**
125% of poverty	**$5600**
150% of poverty	**$6720**
175% of poverty	**$7840**
200% of poverty	**$8960**
300% of poverty	**$13440**

2020 ANCILLARY SERVICE

	LEVEL A	LEVEL B	LEVEL C	LEVEL D	LEVEL E	LEVEL F
Bone Density	**$5.00**	**$7.00**	**$9.00**	**$11.00**	**$13.00**	**Full Ancillary Fee**
Radiology	**$10.00**	**$12.00**	**$14.00**	**$16.00**	**$18.00**	**Full Ancillary Fee**
Ultrasound	**$10.00**	**$12.00**	**$14.00**	**$16.00**	**$18.00**	**Full Ancillary Fee**
Echocardiography/ Vascular Testing	**$10.00**	**$12.00**	**$14.00**	**$16.00**	**$18.00**	**Full Ancillary Fee**
Lab	**$15.00**	**$17.00**	**$19.00**	**$21.00**	**$23.00**	**Full Ancillary Fee**

***Level F is calculated to obtain utilization data and requires payment of 100% of fee associated with ancillary service**

GHC STAFF USE ONLY:

Applicant Name:

Last: _____ First: _____ Account #: _____

_____ The applicant qualifies for the Sliding Fee Program and will be classified as follows:

SLIDE LEVEL: _____

This qualification is for a 12 month period ending: _____/_____/_____

Date card mailed: _____/_____/_____ Date entered in EMR: _____/_____/_____

_____The applicant does not qualify for the Program at this time

Letter of Denial Sent: _____/_____/_____

I attest that I have explained the application to the patient, reviewed all information provided by the patient, confirmed that all required documentation is present, answered all questions related to the application, and have determined the application has been completed in its entirety.

Signature of GHC Staff: _____ Date: _____/_____/_____