



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. If you do not have the prior proof you may sign the Patient Financial Self-Attestation Agreement.

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

OR

____ I acknowledge that I have been provided information related to this Application and **DECLINE** to participate at this time.

Print Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____

Reason for Decline (if applicable): _____

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 Workers Compensation
 Private Short/Long Term Disability Benefits Temporary Assistance for Needy Families
 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 Alzheimer's 3 or more chronic diseases

*If 3 or more chronic diseases are checked, please list: _____

4. Please indicate if you take any of the following medications based on a diagnosed disease (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 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

Patient Attestations (please initial)

If my application is approved, I request all my medications be filled by a GHC pharmacy;

I have the freedom to have my prescriptions filled at any pharmacy and voluntarily choose to use the services of Professional Pharmacy and understand that I can choose another pharmacy of whenever I wish by notifying GHC in writing;

I request that my prescriptions be filled using brand name drugs when available. This statement and request remains in full force and effect until I request otherwise, in writing;

___ I acknowledge that GHC may obtain Prior Authorizations for brand name medications as authorized by me in this document;

___ I agree and request that GHC process all manufacturer coupons on my behalf;

___ I authorize GHC to deliver or mail my prescriptions to me in the event I am unable to pick them up;

___ I agree to take all medication as prescribed and will notify GHC immediately in the event I am unable to follow prescribed medication instructions;

___ I certify under penalty of law based on information and beliefs formed after reasonable inquiry, the statements contained in this document are accurate and complete; and

___ I will actively participate in any programs prescribed by my physicians such as Case Management, Disease Management, Preventive Care, wellness programs, and other such programs and/or services.

I attest that the above information provided to GHC is true and accurate. I understand it is my responsibility to notify GHC of any changes to my income and that I must re-apply for this program every 12 months, or sooner if my family household income changes.

Print Name: _____

Signature: _____

Date: ____/____/____

I decline to utilize a GHC pharmacy to fill my medications and wish to have any prescription medication filled at a different pharmacy of my choice.

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		LEVEL B 100% - 125% FPG		LEVEL C 125% - 150% FPG		LEVEL D 150% - 175% FPG		LEVEL E 175% - 200% FPG		LEVEL F 200% - 300% FPG	
	Nominal Fee of \$15 or *\$0		Pay 15% of Standard Fee		Pay 30% of Standard Fee		Pay 50% of Standard Fee		Pay 70% of Standard Fee		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

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: ____/____/____