Financial Assistance

Sliding Fee Discount Schedule Information

What is the Sliding Fee Discount Schedule?

It is the policy of Heartland Health Services to provide patient-centered primary care regardless of the patient's ability to pay. Discounts are offered based upon household income and the number of persons living in the household. A sliding fee schedule is used to calculate the basic discount and is updated each year using federal poverty guidelines. Once approved, the discount will be honored for one year from the date of application, after which the patient must reapply.

The Sliding Fee Discount Schedule (SFDS) is part of a federal program (Federally Qualified Health Centers - FQHC) that allows Heartland Health Services to discount normal charges for medical visits for our qualifying patients based on household size and household income. In order to qualify for the program, patients must provide proof of income below 200% of the current federal poverty level.

The Sliding Fee Discount is available to all uninsured patients. If you have insurance coverage, Heartland Health Services is required by the FQHC program to bill your insurance for your medical visit charges. You may be responsible for insurance co-pay in this situation. If you have co-insurance or a high deductible, you may submit an application for the Sliding Fee Discount to apply to the patient responsibility portion of the charges.

Depending on household size and household income, patients are assigned a discount tier of full fee, Category A, Category B, Category C or Category D. The minimum fee charged for each tier is shown below:

Discount Tier	**Category A**	**Category B**	**Category C**	**Category D**	**Full Fee**
Minimum Fee	**$25.00**	**$30.00**	**$35.00**	**$40.00**	**Full Charge**

Patients that qualify for the discounted fees are responsible only for the minimum fee in their respective tier and are expected to pay the discounted fee at the time of service unless other arrangements have been made.

How do I sign up for the Sliding Fee Discount?

1. First, complete the Financial Assistance (FA) application included with this informational packet. Instructions are included on the application. Please feel free to ask front desk personnel if you have any questions or need assistance completing the application.

2. Next, you will need to provide proof of income, including the following if applicable:
    - Social Security Income
    - Pension/Retirement Income
    - Alimony Received
    - Child Support Received
    - Unemployment Compensation
    - Disability or Supplemental Security Income (SSI)
    - Rents and/or Royalties Received

3. Attach proof of income – Examples of acceptable proof listed below (copies are acceptable):
    - Prior 2 months of Paystubs
    - Prior 2 months of Bank Statements
    - Income Tax Return for the most recent year
    - Unemployment Verification (Benefit Statement)
    - Court Documents (Alimony and/or Child Support)
    - Benefit Letter (SSI and Social Security recipients, Pension/Retirement recipients)

4. Submit your application with attached proof to any of the clinics at Heartland Health Services or mail to:

    Heartland Health Services
    Attn: Financial Assistance
    2214 N University
    Peoria, IL 61604

5. If you have any questions about financial assistance or filling out the FA application, please contact Michelle at (309) 680-7639.

Sliding Fee Discount Schedule
Financial Assistance (FA) Application

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A completed application, including verification of income, must be on file and approved by the Heartland financial assistance office before a discount will be applied.

Please complete the following information:

I. Patient Information

Patient Name:	Last	First		MI
Address:	Street	City	State	Zip Code
Phone Number		Date of Birth		

II. Guarantor/Guardian Information (If Applicable)

Name of Person Responsible for Paying the Bill			Relationship to Patient	
Address:	Street	City	State	Zip Code
Phone Number		Date of Birth		

III. Household Size Information – List all Individuals in the household for whom you provide financial support*

1.	Name	Relationship to Guardian	Date of Birth
2.	Name	Relationship to Guardian	Date of Birth
3.	Name	Relationship to Guardian	Date of Birth
4.	Name	Relationship to Guardian	Date of Birth
5.	Name	Relationship to Guardian	Date of Birth
6.	Name	Relationship to Guardian	Date of Birth

**Please add additional dependents on the back of this sheet if you need more room*

IV. Household Earnings Information – Please indicate ALL people living in your household who contribute financially, including applicant

Include anyone at least 18 years of age or older who resides in the household and contributes to the basic living expenses of the household (including yourself.) Income includes gross (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, pensions and/or IRA distribution income or other retirement income, etc. (See instructions for complete list.) DO NOT include non-cash assistance such as food stamps, housing allowance, or other government subsidies.

Household Members	Age	Source of Income or Employer Name	Monthly Gross Income
1			
2			
3			
4			
5			
6			

Total Monthly Income $_____

V. Did you file Income Taxes last year? Yes No

VI. **Did you or your spouse receive:**

Unemployment Benefits	Yes	No	_____ If yes, how much per month?
Social Security Retirement	Yes	No	_____ If yes, how much per month?
Social Security disability	Yes	No	_____ If yes, how much per month?
Pension	Yes	No	_____ If yes, how much per month?
Food Stamps	Yes	No	_____ If yes, how much per month?

If unemployed and answered NO to any of these questions, how do you meet your day to day needs?

_____

_____

_____

VII. Do you currently have health insurance? Yes No

If yes, please list health insurance carrier and subscriber ID #:

_____

My signature below represents that the above information is true and correct. I understand that more information may be requested from me if needed. I understand that any falsification of information provided to Heartland Health Services will result in termination of financial assistance.

Signature of Patient or Guardian	Signature of Screener
Date signed	Date signed

Office Use: MRN _____

Family Size: _____

Monthly Income: _____

Sliding Fee Percentage: _____

Approved Date: _____

Approved By: _____

Medicaid Yes No

Reviewed By: _____