HIGH COUNTRY community health

Application for Medical Sliding Fee Scale

An application for each household is required every 12 months.

Date: _____Patient Name: _____

Please include all of the following sources of income for the last 12 months for each household member. (Household members who currently live together and share income and expenses.)

All Employment
SSI Disability
WorkFirst (TANF)
Veteran Benefit
Alimony payments
Retirement Income
Social Security Income
Unemployment
Child Support Payments
Any other Income

OFFICE: OFFICE:

Name	Date of Birth	Relationship to Patient	Source of Income	Gross Income Before Taxes	Pay Frequency	Front Desk Calculated Annual Amount	Front Desk Source of Verification

I certify that the income information given to High Country community Health from me is correct and accurate. Please initial the following:

_____ Sliding Fee Scale eligibility takes effect for all services provided today until 12 months from today. I understand I will need to reapply for the sliding fee scale 12 months from today.

_____ I agree to notify High Country Community Health immediately if my contact or income information changes.

High Country Community Health will not refuse care based on inability to pay.

Responsible Party Signature: _____ Date: _____

Staff Signature: _____ Date: _____

STAFF USE ONLY					
	Household Size:	Annual Gross Income:			
Verified Income:	0 – 100% FPL	101 – 125% FPL	126 – 150% FPL	151 – 200% FPL	>201% FPL

Staff: Please include income calculations in the margin of this form or on separate sheet of paper and scan it into the patients records with all income verification.

HIGH COUNTRY COMMUNITY HEALTH MEDICAL DISCOUNT FEE SCHEDULE (Federal Register Document 83 FR 2462/January 27, 2023)						
	Financial Class A	**Financial Class B**	**Financial Class C**	**Financial Class D**	**Financial Class E**	
Patient Pays	$25 Nominal Fee	$30	$35	$40	Full Charge (**Prompt Pay $80**)	
Federal Poverty Level	0-100%	101-125%	126-150%	151-200%	201% or greater	
Family Size	**Annual Gross Household**					
1	$14,580	$18,225	$21,870	$29,160	> $29,160	
2	$19,720	$24,650	$29,580	$39,440	>$39,440	
3	$24,860	$31,075	$37,290	$49,720	>$49,720	
4	$30,000	$37,500	$45,000	$60,000	>$60,000	
5	$35,140	$43,925	$52,710	$70,280	>$70,280	
6	$40,280	$50,350	$60,420	$80,560	>$80,560	
7	$45,420	$56,775	$68,130	$90,840	>$90,840	
8	$50,560	$63,200	$75,840	$101,120	>$101,120	
For each additional person, add	**$5,140**					
BH	**$10**	$15	$20	$25	Prompt Pay $50	
Dietitican	**$0**	$5	$10	$15	Prompt Pay $30	

HIGH COUNTRY community health

Application for Dental Sliding Fee Scale

Current application is required for each household every 12 months.

Front desk: please include calculations in the margins or attach on a separate piece of paper.

Patient name(s): _____

Please include all of the following resources of income for **the last 12 months for each household member:**

(Household members who currently live together and share income and expenses.)

- All employment income
- Alimony payments
- Any other income
- Veterans benefits
- Unemployment
- SSI Disability
- Retirement Income
- Child Support Payments
- Work First (or TANF)
- Social Security Income

List Name(s) Living In Household Including You	DOB	Relationship to patient	Income Source (Who pays You?)	Gross Income Amount (Before Taxes)	Frequency Paid (How often are you paid?)	Front Desk: Calculated annual amount	Front Desk: Source of verification?

I, the undersigned, certify that the information given by me to High Country Community Health is correct and accurate. **Please <u>initial</u> each line below beside the ⇨ arrow thank you.**

⇨_____Sliding Fee Scale Eligibility is effective for all services provided today until 12 months from today. I understand that I need to reapply for the Sliding Fee Scale <u>12 months from today.</u>

⇨_____I understand that if documentation is not presented today that I am responsible for the full amount of my bill and additional lab costs.

⇨_____I also agree to notify HCCH immediately if my contact or income information changes.

HCCH sliding fee scale is based on the 2023 Poverty Guidelines. Responsible

Party Signature: _____Today's Date: _____ Staff

Signature: _____

FOR OFFICE USE ONLY:		HH size:		Annual Gross Income:	
Verified income:	0-100% FPL	101-150% FPL		151-200% FPL	201% or greater FPL

High Country Community Health

Dental Services

2023 POVERTY GUIDELINES

ANNUAL GUIDELINES

PERCENT OF POVERTY GUIDELINE

	<100%	101-125%	126-150%	151-200%
	Slide A	**Slide B**	**Slide C**	**Slide D**
Family Size		60% Discount	50% Discount	40% Discount
1	$ 14,580	$ 18,225	$ 21,870	$ 29,160
2	$ 19,720	$ 24,650	$ 29,580	$ 39,440
3	$ 24,860	$ 31,075	$ 37,290	$ 49,720
4	$ 30,000	$ 37,500	$ 45,000	$ 60,000
5	$ 35,140	$ 43,925	$ 52,710	$ 70,280
6	$ 40,280	$ 50,350	$ 60,420	$ 80,560
7	$ 45,420	$ 56,775	$ 68,130	$ 90,840
8	$ 50,560	$ 63,200	$ 75,840	$ 101,120

For family units of more than 8 members, add $5,140 for each additional member.

>200%

Self Pay
>$29,160
>$39,440
>$49,720
>$60,000
>$70,280
>$80,560
>$90,840
>$101,120

SLIDE A (SF BASIC) SPECIALITY FEES		
Treatment		Prices
BRIDGE	(370 per unit)	
	3-unit Bridge	$1,110
	4-unit Bridge	$1,480
	5-unit Bridge	$1,850
	6-unit Bridge	$2,220
CROWN		
	Stainless Steel	$120
	Porcelain/Ceramic	$370 each
DENTURE		
	Complete	$506
	Immediate	$546
	Interim-Partial	$299
	Interim-Complete	$338
	Pediatric	$296
PARTIAL		
	Resin Base	$426
	Metal Base	$591
	Flex Base	$634
ROOT CANAL		
	Permanent Tooth	$244
	Decidious/Baby Tooth	$80
	Build Up	$80
MISCELLANEOUS		
	Occlusal Guard	$200
	Denture RELINE	$185
	Denture REPAIR	$80
	Re-cement Crown	$40