adapt
Integrated Health Care

Due Date _____

SLIDING FEE DISCOUNT PROGRAM

Please keep this page for your records.
Please complete the next page and return it to Adapt by the due date shown above.

Adapt Integrated Health Care offers a Sliding Fee Discount Program to help lower the cost of care for patients who qualify. **All patients are encouraged to apply for a Sliding Fee Discount**, including patients with insurance. Eligibility is based on family size and combined household income. No one is turned away due to lack of funds.

- You must return the Sliding Fee Discount Application form within 14 days of your visit to get a discount for that visit. If you return it later, the discount will start on the date we receive it.
- Discounts cannot be applied to past visits.
- After we process your application, you will get a letter in the mail telling you what discount you qualify for.
- Discounts last for one year. At that time, you will need to provide updated proof of income. If your financial or living situation changes before then, you must tell Adapt. Your discount may change.
- All patients will receive a monthly statement if there is a balance owed on their account. All balances are due within 30 days of the statement date. If you are unable to pay your balance in full, call the Adapt billing office to make payment arrangements.
- The information on this form may also be used to see if you qualify for a discount on CHI Mercy Health Outpatient Lab & Imaging services ordered by Adapt Primary Care. To get a discount from CHI Mercy Health, you must first apply for the Oregon Health Plan. CHI Mercy Health may request this information for review.

Required Documents: To apply for a Sliding Fee Discount, include copies of the required documents for everyone in your household. **If a document does not apply to your household, you can skip it**.

- ☐ Most recent 30 days of pay stubs
- ☐ Unemployment verification
- ☐ Most recent federal tax return (if self-employed)
- ☐ Social Security and/or Disability award letters
- ☐ Pension award letter
- ☐ Child Support award letter
- ☐ Workers' Compensation award letter
- ☐ Court orders from any lawsuit
- ☐ Proof of gambling winnings
- ☐ Proof of annuity payments
- ☐ Receipts for goods sold or services provided
- ☐ If you have no income, a letter that explains your means of living or a completed Self Attestation of Income form (available upon request)
- ☐ Food Stamps verification
- ☐ Tuition assistance grants

Definitions:

Household: persons who live in the same dwelling and are pooling resources.

Income: any moneys received, whether taxable or non-taxable, from any source. Any moneys for goods sold or services provided, grants for tuition assistance, retirement income, business income, social security and/or disability payments, unemployment insurance benefits, settlement awards from any lawsuit whether considered "economic damages" or not, life insurance payments, annuity payments, gambling winnings, and any other moneys received for the purposes of assisting with household expenses will be included. Loans or available credit will not be counted.

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Patient Last Name	First Name	MI

Do you want to apply for a Sliding Fee Discount?	
☐ **Yes, I want to apply** If "Yes," please fill out the rest of this form as fully as you can and sign below.	☐ **No, I do not want to apply** If "No," you can apply later at any time. Please sign and date here: Patient Signature: _____ Date: _____

If you are applying for a Sliding Fee Discount, you may also qualify for the Oregon Health Plan (OHP). If you want to apply for OHP and would like free help, ask to speak with an outreach eligibility worker.

Have you applied for the Oregon Health Plan? **Y N** If yes, date applied: Were you approved? **Y N**

Do you have other insurance? **Y N** If yes, what insurance?

PLEASE PROVIDE INFORMATION FOR THE PERSON RESPONSIBLE FOR THIS ACCOUNT BELOW.

Name of Responsible Party: Relation to Patient:

Social Security (optional last 4): XXX-XX- Date of Birth: Phone:

Billing Address: City: State: Zip:

Please provide information for all household members. See definition of "household" on page 1.

Household Member	**1**	**2**	**3**	**4**	**5**	**6**
Name						
Date of Birth						
Relationship to Patient	SELF					
Gross Monthly Income from ↓	**Please provide supporting documentation for each source of income listed.**					
Salary/Wages	$	$	$	$	$	$
Unemployment	$	$	$	$	$	$
Social Security	$	$	$	$	$	$
Disability	$	$	$	$	$	$
Pension	$	$	$	$	$	$
Retirement	$	$	$	$	$	$
Child Support	$	$	$	$	$	$
Worker's Comp	$	$	$	$	$	$
Sale of Goods	$	$	$	$	$	$
Other: _____	$	$	$	$	$	$
TOTAL	**$**	**$**	**$**	**$**	**$**	**$**

TOTAL gross monthly household income: _____ **TOTAL** number of household members: _____

If your household income is zero, please initial here: _____ and provide a brief explanation of your current financial and living situations: _____

I hereby authorize representatives of Adapt to make whatever inquiries necessary to verify the information furnished on this form, or to release any information regarding my office visits to any insurance company or third party to seek settlement of this account. I hereby state that to the best of my knowledge the information given above is true and complete. I understand that if any information is found to be incorrect, I may not be eligible for any future consideration of reduced rates and that any sliding fee taken in the past may be reversed and all accounts adjusted accordingly.

Patient/Responsible Party Signature: _____ Date: _____

**********FOR OFFICE USE ONLY**********

Application Date: _____ Expiration Date: _____

☐ **Based on the information provided, the above listed patient is eligible for a _____% discount.**

☐ **Based on the information provided, the patient is <u>not</u> eligible for a discount at this time.**

☐ **Patient declined to apply for a Sliding Fee Discount**

Information verified by: ☐ Pay Stubs ☐ Tax Return ☐ Other _____

Staff member completing form: _____ Date: _____