Billing Policy and Sliding Fee Application

Catherine's Billing and Collections Policy

Catherine's Health Center provides access to services regardless of a person's ability to pay. Catherine's accepts a variety of insurance plans, Medicaid, and Medicare. **Patients may qualify for a discount for services—a sliding fee schedule— based on household income and family size.** The sliding fee schedule will be applied to charges for patients who are between 100% and 200% of Federal Poverty Level (FPL). For individuals and households with income at or below 100% of the FPL, Catherine's services will be provided for a minimum fee. Please ask the front desk for more information.

If the patient is responsible for any charges, payment must be made at the time of checkout. Outstanding balances will be directed to a collection's agency. To ensure that everyone who needs care has access to it, Catherine's reserves the right to suspend services to a patient if payment is not made and if the sliding fee application is incomplete or inadequate.

By signing below, I acknowledge that I have reviewed the billing policy information above and/or have requested the additional information I require for full understanding.

Sliding Fee Application

This application is available to every person, regardless of insurance status.

☐ I declare that I am unhoused.

☐ I decline to provide the following information and so acknowledge that I will be ineligible to receive financial assistance. Therefore, if I am responsible for any charges, I will pay the full billed amount.

Full Legal Name of Patient & Signature ____________________ Date ____________

Please list yourself, spouse, and dependents **that you claim on your taxes.**

Name		Date of Birth	Name		Date of Birth
Yourself			Dependent/Age		
Spouse			Dependent/Age		
Dependent/Age			Dependent/Age		
Dependent/Age			Dependent/Age		

Yearly Household Income

Source of Income	Yourself	Spouse	Other	Total Income
Gross wages, salaries, tips, etc.				
Social security & veteran's benefits (circle applicable choices)				
Alimony				
Income from business self-employment, and dependents (circle applicable property)				
Rent (if you own property)				
Total Income				

Verification Checklist

Please attached all copies to this form

☐ **Yes** ☐ **No** *Identification/Address:* Driver's license, employment ID, social security card, or other

☐ **Yes** ☐ **No** *Income required:* Prior year tax return, one month of pay stubs, W-2, social security benefits, support letter, or other

☐ **Yes** ☐ **No** *Insurance:* Insurance card(s)

☐ **Yes** ☐ **No** *Medicaid:* Application made or evidence of rejections

Patient/Guardian Signature (Legal Name) ______________________ Date ______________

OFFICE USE ONLY

Pay class approved:	Effective Date:
Approved by:	**Expiration Date:**