Catherine's HEALTH CENTER

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. If the patient is responsible for any charges, payment must be made at the time of checkout. **Any patient may request to be placed on a payment plan if they are not able to keep up with their payments.** Patients may also apply for a discount for services-a sliding fee schedule-based on household income and family size. More information about how to apply for the sliding fee schedule can be found below. 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.

_____ _____

Patient/Guardian Signature (Legal Name) **Date**

Sliding Fee Program

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

Please choose one of the options below to either apply for the Sliding Fee Program or Decline.

☐ I would like to apply for the Sliding Fee Program.

☐ I decline to apply for the Sliding Fee Program 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.

If you decline to apply for the Sliding Fee Program, you can stop here. If you would like to apply, please fill out the application on the next page.

Sliding Fee Application

Please choose the best option that reflects your current living situation:

☐ I declare that I have housing.

☐ I declare that I do NOT have housing (which could include: being homeless, staying in supportive or transitional housing, staying in a shelter, or being part of a program to support people without homes)

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

Full Name:_____Date of Birth:_____

Spouse Full Name:_____ Date of Birth: _____

Dependent Full Name: _____ Date of Birth:_____

Dependent Full Name:_____ Date of Birth:_____

Dependent Full Name: _____ Date of Birth:_____

Dependent Full Name:_____Date of Birth:_____

Yearly Household Income

Income Source	Yourself	Spouse	Other	Total Income
Gross wages, salaries, tips, etc.				
SSI and VA Benefits (Circle applicable choice)				
Alimony				
Income from business self-employment, and dependents (circle applicable property)				
Rent (if you own property)				

Total Income

By signing below, I attest that all the information on my Sliding Fee Application is correct to the best of my knowledge.

_____ _____

Patient/Guardian Signature (Legal Name) **Date**

_____***OFFICE USE ONLY***_____

Verification Checklist

Please attach **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*

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