

SLIDING SCALE

What is a Sliding Fee?

Sliding fee refers to the reduction (i.e. slide) of our normal charge to a lower charge for services provided at Whitefoord, Inc. Health Centers.

How is a reduction in fee determined?

Sliding fee is determined based on your income level and the number of members in your household. Using this information our staff computes the amount of sliding fee reduction based on Federal poverty guidelines. Whitefoord, Inc. will reduce the amount of your patient responsibility on any outstanding balances owed by you or a named dependent in this application for basic health service, elective service will not be discounted.

How can I qualify for a sliding fee?

To qualify for sliding fee, you will need to provide us with your income information and the number of members in your household.

What type of documentation do I need to provide?

We will need a copy of page 1 of your most recent **federal income tax return** (Form 1040 or 1040A) and a **copy of recent wage statements, unemployment or pay stubs** a statement/letter from your employer showing year to date earnings can be substituted for pay stubs if one is not available. A **copy of your current driver's license or current utility bill with your name and street address** or other legal document is required to proof your identity. ***This information is only used for determining your identity and is held in strict confidence.*** Once approved, the sliding fee reduction will be good for one year or whenever your income and/or family size changes. If you continue to receive services, you may be asked to re-apply.

What happens if I don't provide the documentation?

We will compute your sliding fee discount based on your information provided. You will be asked to send in the required information within one week. Without this documentation, you will receive a bill for the full amount of the charges, which are due within 10 days from the date of service. If you need a return visit to our clinics in the future, we will require that documentation be on file to continue qualifying for the sliding fee discount. If the required documentation is not on file, you will be charged our usual charges for the services provided. Qualifying must be updated on annual basis or whenever your income and/or family size changes.

Whitefoord Elementary School Health Center 35 Whitefoord Avenue Atlanta, Georgia 30317 (404) 588-0101 Ext 10	King Middle School Health Center 545 Hill St SE, Atlanta, GA 30312 (404) 373-3530	Whitefoord Family Medical Center 30 Warren Street Atlanta, GA 30317 (404) 373-2282 Ext 10
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ABOUT WHITEFOORD, INC. SLIDING SCALE

We offer a sliding fee scale for patients whose family income is at or below 200% of the federal poverty level. It may be possible that you qualify for Medicaid or Basic Health Plan coverage, our staff will assist you in obtaining those applications. Our Health Center Representative will ask you a few questions to determine whether you might be eligible for these plans.

INCOME VERIFICATION

In order to qualify for our sliding fee, you must complete our sliding fee scale application listing household members and household income for every member listed on the application.

Below are examples of the kinds of documentation required to verify your household's income:

- A copy of last two month's pay stubs or letter from employer
- Unemployed- a copy of last two month's unemployment check stubs, or current pay stub from most recent employer (for the last 60 days). A Wage Inquiry from the Department of Labor is also acceptable.
- Self-employed- Last W2's, Form 1099, self-employment ledger or official copy of self-employment tax forms that has been signed and filed.
- Verification of disability income
- Award letter for public assistance, military allotments, scholarships, etc.
- Court order or Support Enforcement receipt for child or spousal support.
- If no income whatsoever, and you are being provided room and board by someone else, a letter stating this from the people providing your room and board.

If you are eligible for our sliding fee, charges for your services will be discounted. Full fee will be charged if no proof of income is provided.

APPLICATION FOR WHITEFOORD INC. HEALTH CENTERS SLIDING SCALE

We offer services on a sliding fee scale. In order to determine if you qualify for the sliding fee scale, please provide the following information.

How many people are supported by this income? _____

Use the number of persons in your family who live in the same household and who share income, food and/or rent. That number includes you, your spouse, and/or any dependents.

FULL NAME	RELATIONSHIP TO YOU
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How much MONTHLY gross income in your household and where it comes from:

Employment	\$ _____	Disability	\$ _____
Unemployment	\$ _____	Pension Funds	\$ _____
Self-Employment	\$ _____	Savings/Trusts	\$ _____
Social Security	\$ _____	VA Benefits	\$ _____
Child Support	\$ _____	Spousal Support	\$ _____
Public Assistance	\$ _____	Food Stamps	\$ _____
Housing Allowance	\$ _____	Training Stipends	\$ _____
Military Family Allotments	\$ _____	Scholarships/Grants	\$ _____
Allowance/Gifts	\$ _____	Other Income	\$ _____
Support from an Absent Family Member	\$ _____		

TOTAL MONTHLY INCOME \$ _____

To the best of my knowledge, the information given is true and correct. I give the WHITEFOORD , INC. Health Centers Accounts permission to verify information about my financial status. I understand this information must be provided to qualify for the sliding fee discount. If this information is not received within one week, then I understand that I will be billed the FULL fee for the visit, which will be due within 10 days from the date of service. I understand that Whitefoord, Inc. may verify this information through other third party resources and I will not be charged verification fees.

Patient Name _____
Please print full name

Patient Signature _____

Parent Signature _____
(If applicable)

Date _____