SLIDING SCALE

What is a Sliding Fee?

Sliding fee refers to the reduction (i.e. slide) of 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. Additional document to proof your identity include a copy of driver's license, ID or other legal document. *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 Based Health Center 35 Whitefoord Avenue Atlanta, Georgia 30317 (404) 588-0101 Ext 10	***King Middle School Based Health Center 545 Hill St SE, Atlanta, GA 30312 (404) 373-3530***	***Toomer Elementary School Based Health Center 65 Rogers St. NE Atlanta, GA 30317 (404)-373-2282***	***Whitefoord Family Medical Center 30 Warren Street Atlanta, GA 30317 (404) 373-6614***

Revised February 2018

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. We need proof of income and information about household members to determine sliding fee scale eligibility. It may be possible that you qualify for public health insurance 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	$_____________	Housing Allowance	$____________
Training Stipends	$_____________	Allowance/Gifts	$_____________
Military Family Allotments	$_____________	Scholarships/Grants	$_____________
Support from a Family Member	$______________	Other Income	$_____________

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______________________________ **Patient Signature**___________________________
Please print full name

Parent Signature___________________________________ **Date**________________________________
(If applicable)

Revised February 2018