**COMMUNITY HEALTH PROGRAMS**

# SLIDING FEE SCALE APPLICATION

Dear Applicant(s):
Community Health Programs (CHP) offers a sliding fee scale to uninsured/underinsured patients and their families living in Berkshire County. Eligibility for the sliding fee scale is based on patient's family unit size and anual household income. Please complete this application as much as you can. **Eligibility must be verified prior to enrollment and once quarterly thereafter.** Once verified by the CHP Patient Assistance Coordinator/Enrollment Specialist, reduced fees will be effective upon enrollment or, for those already enrolled, on the 1st day of the month following income verification. In the event a family experiences a substantial drop in income, they have the option of going through the verification process again at any time. Thank you for your cooperation.

## APPLICANT INFORMATION

First name_____ Last name_____
SS#_____ Date of birth_____ Berkshire Co. resident? **YES / NO**
Home address: _____
_____ Homeless? **YES / NO**
Mailing address if different: _____
Tel. (home/work)_____ (*Circle one*: Male / Female)

## OTHER FAMILY MEMBERS (spouse or children under 19 living with you)

Name_____ SS#_____ Date of birth_____
Name_____ SS#_____ Date of birth_____
Name_____ SS#_____ Date of birth_____
Name SS# Date of birth

## WORKING*

Who is working in the family?
**1.** _____ (*Circle one*: full time / part time)
Number of hours per week:_____ Amount paid per hour: $_____
Employer name/address/tel.: _____
**2.** _____ (*Circle one*: full time / part time)
Number of hours per week:_____ Amount paid per hour: $_____
Employer name/address/tel.: _____
***IF SELF-EMPLOYED***, annual income after deductions: $_____
*** Please provide 2 recent pay stubs, or federal income tax return, or signed statement by the employer.***

## NOT WORKING

Are you **unemployed?** **YES / NO**
Do you get unemployment benefits? **YES / NO** How much a week? $_____

## MISCELLANEOUS

- Do you or any family member have any other source of income (*Social Security, pension, worker's compensation, child support, etc.*)? **YES / NO** (if yes, how much? $_____)
- Are you covered by any health insurance (*Medicare, MassHealth, CommCare*)? **YES / NO**

**The above information is true to the best of my knowledge.**

Applicant's signature: _____ Date: _____

Discount/Charity Programs for the Uninsured *613.08(1)(c)2f*
CHP offers Sliding Fee Discounts to patients who are ineligible for the Health Safety Net. For these patients, CHP offers full discount to patients under 100% of the Federal Poverty Income Guidelines (FPIG) and Sliding Fee Discounts to patients with incomes between 100% and 150.1% of the FPIG.

**Our sliding fee scale is based on patient's family unit size and annual household income compared to the current federal poverty income guidelines shown below.**

| Family Unit | $10.00 Nominal Fee | 20% pay | 40% pay | 60% pay | 80% pay | 100% pay |
|---|---|---|---|---|---|---|
| **Poverty** | **100%** | **125%** | **150%** | **175%** | **200%** | **201%** |
| 1 | 11,880 | 14,850 | 17,820 | 20,790 | 23,760 | 23,761+ |
| 2 | 16,020 | 20,025 | 24,030 | 28,035 | 32,040 | 32,041+ |
| 3 | 20,160 | 25,200 | 30,240 | 35,280 | 40,320 | 40,321+ |
| 4 | 24,300 | 30,375 | 36,450 | 42,525 | 48,600 | 48,601+ |
| 5 | 28,440 | 35,550 | 42,660 | 49,770 | 56,880 | 56,881+ |
| 6 | 32,580 | 40,725 | 48,870 | 57,015 | 65,160 | 65,161+ |
| 7 | 36,730 | 45,913 | 55,095 | 64,278 | 73,460 | 73,461+ |
| 8 | 40,890 | 51,113 | 61,335 | 71,558 | 81,780 | 81,781+ |