SLIDING FEE DISCOUNT PROGRAM

neighborcare health

Neighborcare Health's Sliding Fee Discount Program follows federal guidelines based on household size and income. **Patients need to:**

- Make an appointment with an eligibility specialist to complete an application.
- Provide proof of information regarding household size, gross household income, and identity information for all individuals contributing to household income.

Applications and printed copies of supporting documents must be given directly to an eligibility specialist or a front desk staff member at your clinic. They cannot be mailed or faxed.

HOUSEHOLD INCOME DOCUMENTATION EXAMPLES:

❑ **Proof of 30 days gross income for every member of the household contributing to income.** Specifically, all types of earned and unearned income. Examples include: 1040 Federal Tax Form, pay stubs/wages and tips/gratuities, back pay, bonuses, military pay, self-employment, hobby income, compensation for personal services, income from interest or annuities, dividends, capital gains, pension, rent, royalties and foreign income, last two unemployment check stubs, alimony, IRA distributions, etc.

❑ **If you have no income,** provide a letter of support or reference from an organization/individual and a signed statement of zero income.

IDENTITY VERIFICATION:

❑ A current photo ID such as driver's license, state-issued identification card, military ID, etc.

Please provide the information listed above (or any other documentation needed by Neighborcare Health, on a case-by-case basis) within forty-five (45) days of your visit with your provider, or you must pay the full amount for those charges.

❑ ***I choose not to provide income information and understand that I will be responsible for full payment of services rendered.***

LIST YOURSELF AND ALL THE MEMBERS OF YOUR HOUSEHOLD:

Name:		Date of Birth:		Name:		Date of Birth:	
Name:		Date of Birth:		Name:		Date of Birth:	
Name:		Date of Birth:		Name:		Date of Birth:	
Name:		Date of Birth:		Name:		Date of Birth:	

IF YOU HAVE HEALTH INSURANCE, COMPLETE THIS SECTION:

Insurance Name:		Subscriber Name/ Patient Name:		
Policy Number:		Group Number:		
Insurance Phone:		Work Phone:		
Relationship to subscriber:		Subscriber's Date of Birth:	/ /	(sex) ❑ M ❑ F

I understand the above information and agree that I will provide proof of information to verify my household size, household income, and personal identity of household members contributing to income. I understand that if I do not provide this information within forty-five (45) days of my visit with my provider, I will be billed at full fee. I agree to pay all costs not covered by my insurance carrier.

Neighborcare Health's Sliding Fee Discount Program does not cover inpatient OB services and procedures.

If you are pregnant, please schedule an appointment with eligibility to determine if you qualify for either state-sponsored insurance or Medicaid. If you do not qualify, you will be asked to sign a Prenatal Agreement and set up a payment plan. Please contact a Patient Account Specialist (206-548-3100) for more information.

Signature		Date Requested:			Date Verified:		
Print Name of Patient		Expiration Date:			MRN/ Account #:		
Main Phone		Household Size:		Yearly Income:		Scale:	
Personal Email		Entered in system by:				Date:	

* ALL INFORMATION NEEDS TO BE UPDATED ANNUALLY/UPON REQUEST *