Central Florida Health Care

Sliding Fee Scale Discount Program Application

It is the policy of Central Florida Health Care, Inc. (CFHC) to provideservices defined within the scope of project regardless of the patient's ability to pay. Discounts are offered based on family size and income. The discount will apply to services received at our facility but will not cover those supplies purchased outside of the health center.

Please complete the following information below to determine if you or your family members are eligible for our sliding fee scale program. Discounts apply for 365 days from the date of approval and will be re-assessed every 365 days after that. CFHC will reassess a patient's income levels anytime there is a change in their pay status throughout the year.

Family is defined as a group of two or more people related by birth, marriage, adoption and/or living together. The residence to be considered in establishing family size will be the location of the collective family.

Please list Household Members below:

Name	Date of Birth	Relationship	Age
		SELF	
		SPOUSE/PARTNER	

Please list Household Income below:

As a Community Health Center, CFHC is are required by law to obtain proof of income for our records. Proof of income includes income from all sources for adults listed above. Sources of income include, but are not limited to: gross wages, tips, social security, disability, pensions, annuities, veterans' payments, self-employment income, alimony, child support, military, unemployment public aid and any other sources of income excluding non-cash benefits. Please ask your CFHC center for a list of acceptable documentation of income.

Household Income (complete one column) - Household Income must include self, spouse, dependents over 18 and any other household members over the age of 18.

	Annual	Monthly	Every Other Week	Weekly
Self				
Spouse				
Dependent over 18				
Dependent over 18				
Dependent over 18				
Total				

A financial assessment is required to determine what discount you and your family may qualify for based on your household size and income. If you do not have the necessary information available, you will have 30 days to provide additional forms of documentation of income to remain eligible for SFDS program. If documentation is not received within 30 days, you will be responsible for 100% of all charges incurred from the date of this application until such documentation is provided.

I certify that the family size and income information shown above is correct

Printed Name of Patient/Guardian _______________ Date of application _______________

Signature of Patient/Guardian _______________ Patient ID# (Staff to Complete) _______________

Sliding Fee Scale Discount Acknowledgement Form

Name of Guarantor:	Name of Patient:	DOB:	Patient's ID #:

Based on the above information, CFHC staff has preliminarily determined that your Sliding Fee Discount Classification is:
(STAFF WILL CIRCLE ONE OF THE BELOW SLIDE CATEGORIES)

Discounted Charge Classification	Nominal / Minimum Charge Dental & OB	Nominal / Minimum Charge Medical, GYN, Behavioral Health, & Optical	Nominal Charge Lab per visit	Nominal Charge Radiology per test	Nominal / Minimum Nutrition / Dietition Services	Nominal/ Minimum ASD Devel-opmental Evaluation	Income Criteria
Slide A* 0%	$50.00	$25.00	$25.00	$15.00	$5.00	$116 Per Hour	At or below 100% FPG**
Slide B* 25%	$50.00	$25.00	$35.00	$15.00	$5.00	$141 Per Hour	101-150% FPG**
Slide C* 50%	$50.00	$25.00	$35.00	$15.00	$5.00	$141 Per Hour	151-175% FPG**
Slide D* 75%	$50.00	$25.00	$35.00	$15.00	$5.00	$141 Per Hour	176-200% FPG**
Slide E* 100%	100%	100%	$35.00	$15.00	100%	$141 Per Hour	201% or above FPG**

Nominal fees are a single amount per visit expected to be paid when you check in for your appointment and qualify for the Slide A*0%. Slides B, C, and D have a minimum amount that is expected to be paid at time of check in. Set or additional charges apply to Purchased Services/Equiptment i.e.(dental prostetics, glasses and frames, etc.)

I hereby acknowledge that the sliding fee scale discount program has been explained to me including the charges and terms of payments. I agree to the classification that I am assigned. I also understand the CFHC Billing Office will be reviewing all documentation provided and confirming classification eligibility.

Signature of Guarantor

Date

Expected expiration date of the discount program and the classification I have been assigned is (365 days) one year from the date of this application.

Central Florida Health Care Inc. is an Equal Opportunity Employer. CFHC Inc. does not provide preferential treatment to any one patient. CFHC Inc. provides preventative and primary medical,dental,vision, behavioral health and nutritional services to eligible patients regardless of their "ABILITY TO PAY". Every patient has the right to seek services at CFHC Inc. free from all forms of discrimination. All patients will be treated without regard to age, sex, color, religion, race, national origin, citizenship, veteran status, current or future military or familial status, sexual orientation, gender identification, marital and status, physical or mental disability, legal source of income or any other status protected by laws.