## Summit County Public Health

## Sliding Fee Discount Program

At Summit County Public Health, we are dedicated to providing quality healthcare services to all patients regardless of financial barriers.

If you are uninsured and have a low income, you may qualify for a sliding fee discount for your medical or dental services. This program is made available by Summit County Public Health to provide medical and dental care for people who otherwise may be unable to afford it.

The discount applies only to office visits provided by our clinic staff; lab services billed by our clinic may be reduced but will not be charged at less than our cost. Adult vaccines are excluded from the sliding fee discount program.

If you wish to qualify for the sliding fee, you must show proof of gross annual income for all family members living in your household. Gross income means your paycheck before deductions, pension, retirement, or social security income, cash child support, alimony, workers compensation payments, etc. from all sources in the family. Acceptable proof of income documents include: one month of most recent paycheck stubs, bank deposits, social security determination letter, prior year tax return or W-2.

To apply, you must complete the Summit County Public Health Application for a Sliding Fee Discount (on the reverse side of this page) and bring it with you to your appointment or return it to our Billing Office as soon as possible. Until this process is completed, you will be responsible for the full charges. If you appear to be eligible for Medicaid, we will assist you with the application. Eligibility for the sliding fee discount program will be re-assessed if you are denied. Failure to comply with the Medicaid application process will cause you to be ineligible for our sliding fee discount program.

Summit County Public Health Staff will use the table below to determine your eligibility. Your discount will be assessed on a yearly basis. You are expected to pay the discounted rate or nominal fee for services. If you cannot pay at the time of service, please make arrangements for payments with a member of our billing team.

If you have any questions, please contact the Summit County Public Health Billing Office at (330) 926-5675.

| Annual Income for Sliding Fee Scale Consideration | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Poverty Level*** | | **At or Below 100%** | **125%** | **150%** | **175%** | **200%** | **Above 200%** |
| | | **Charge** | | | | | |
| **Family Size** | **Income** | **Nominal Fee ($25.00)** | **20% pay** | **40% pay** | **60% pay** | **80% pay** | **100% pay** |
| **1** | Annual | 0-$12,490 | $12,491-$15,613 | $15,614-$18,735 | $18,736-$21,858 | $21,859-$24,980 | $24,981 + |
| **2** | Annual | 0-$16,910 | $16,021-$21,138 | $21,139-$25,365 | $25,366-$29,593 | $29,594-$33,820 | $33,821 + |
| **3** | Annual | 0-$21,330 | $21,331-$26,663 | $26,664-$31,995 | $31,996-$37,328 | $37,329-$42,660 | $42,661+ |
| **4** | Annual | 0-$25,750 | $25,751-$32,188 | $32,189-$38,625 | $38,626-$45,063 | $45,064-$51,500 | $51,501+ |
| **5** | Annual | 0-$30,170 | $30,171-$37,713 | $37,714-$45,255 | $45,256-$52,798 | $52,799-$60,340 | $60,341+ |
| **6** | Annual | 0-$34,590 | $34,591-$43,238 | $43,239-$51,885 | $51,886-$60,533 | $60,534-$69,180 | $69,181+ |
| **7** | Annual | 0-$39,010 | $39,011-$48,763 | $48,764-$58,515 | $58,516-$68,268 | $68,269-$78,020 | $78,021+ |
| **8** | Annual | 0-$43,430 | $40,891-$54,288 | $54,289-$65,145 | $65,146-$76,003 | $76,004-$86,860 | $86,861+ |
| **For each additional person, add** | | $4,420 | $5,525 | $6,630 | $7,735 | $8,840 | $8,840 |

* Based on 2019 Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)

**SUMMIT COUNTY PUBLIC HEALTH APPLICATION FOR SLIDING FEE DISCOUNT**

| **PATIENT INFORMATION** | | | DATE: |
|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | Other Name: |
| Home Address: | City: | State: | Zip: |
| Mailing Address: | City: | State: | Zip: |

| Home Phone: | Cell Phone: | Date of Birth: |
|---|---|---|

Have You Applied for Ohio Medicaid? YES NO

Are you able to obtain health insurance through an employer or other means? YES NO

| **HOUSEHOLD INFORMATION** | | |
|---|---|---|
| Name (list all household members): | Date of Birth: | Gross Monthly Income: |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | TOTAL MONTHLY INCOME: | |
| | TOTAL HOUSEHOLD MEMBERS: | |

| **OTHER INCOME** | |
|---|---|
| Income Type (please list for all household members) | Monthly Amount |
| Social Security | |
| Public Assistance | |
| Retirement Pension | |
| Food Stamps | |
| Interest Income | |
| Child Support/Alimony | |
| Other | |
| TOTAL: | |

Are there special circumstances that impact your ability to pay for medical/dental care? If so, please explain:

_____

_____

I certify that all the information provided is true and correct to the best of my knowledge. I understand that the information is to be used to determine my ability to pay for services, which are rendered to me by Summit County Public Health. I understand that submission of false information will automatically disqualify me for any type of assistance.

Responsible Party Signature: _____ Date: _____

FOR OFFICE USE ONLY

Proof of income documents received: [ ] Pay Stubs [ ] Prior year tax return [ ] Social Security determination
[ ] Bank deposits [ ] Statement of Sustainability. A copy of each document must be attached to this application.

Eligible for discount of _____% Beginning: _____ Ending: _____

Signature of Staff _____ Date: _____