Policy #: **2402**	Policy Title: **Federal Sliding Fee Scale**
Department: **Finance** Original Author: **S. Burke** Effective Date: **11/03**	Author/Editor: **S. Burke, D. Huffman, J. Lefebvre, K. Cournoyer, O. Fadahunsi** Revision date(s): : **11/04, 3/05, 5/07, 4/08, 4/09, 3/10, 4/10, 02/11, 4/12, 04/13, 2/14, 06/14, 3/16, 4/3/17, 4/9/18, 2/25/19, 6/10/19, 5/27/20, 4/26/21, 4/04/2022, 2/27/23** Review Date(s): **8/10, 2/27/23, 4/8/24**
Reference(s): (optional – if included, listed at end document)	Accreditation Standard(s):
Approvals:  **Louis Brady, President/CEO**	

POLICY STATEMENT

Providing high-quality primary care services to underserved populations is the mission of the Family Health Center of Worcester, Inc. (FHCW) mission. FHCW is committed to providing high-quality, integrated care to all patients through the Patient-Centered Medical Home Model. FHCW Policies and Procedures will follow the organization's goals, mission, and clinical guidelines. It is the policy of the Family Health Center of Worcester (FHCW) that no patient will be denied health care services due to the inability to pay for such services upon meeting specific eligibility criteria.

PURPOSE

This policy ensures that all Family Health Center of Worcester, Inc. (FHCW) patients have access to services for which there is a health center charge regardless of ability to pay so that the costs to the patient do not present a barrier to care. This policy outlines the principles governing the Sliding Fee Scale discounts (SFSD). This policy complies with Section 330(k)(3)(G) of the Public Health Service Act, 42 CFR § 51c.303(f) and applicable Health Resources and Services Administration (HRSA) policy regarding providing a schedule of fees for services, and a corresponding schedule of discounts for eligible patients that are adjusted based on their ability to pay. The SFSD is available to patients whose documented income does not exceed 200% of the current Federal Poverty Level (FPL) Guidelines updated annually by the federal government (see Attachment A-1). The Commonwealth of Massachusetts has the Health Safety Net (HSN) available, which pays for some health services provided by acute care hospitals or community health centers. FHCW uses the state's current HSN guidelines for uninsured and/or underinsured Massachusetts residents. This includes individuals visiting the United States for personal pleasure or to receive medical care in a setting other than a nursing facility that does not meet the residency requirements for the federal sliding fee discount.

SCOPE

This policy applies to all sites of FHCW, all in-scope required, and additional health services within HRSA approved scope of the project, for which the health center has established a charge for reimbursement from patients and payers.

RESPONSIBILITY

The CFO, COO, and the directors/ managers responsible for the overall operations of all health center sites oversee the implementation and application of this policy. The Board of Directors is responsible for annually approving the FHCW Sliding Fee Scale discount policy and the supporting procedures. The SFSD will be evaluated annually for its effectiveness in addressing financial barriers to care and updated as necessary. FHCW's Board must approve all amendments to the SFSD.

SCHEDULE OF FEES

FHCW will maintain a Board-approved schedule of fees for the provision of services. The schedule of fees will be used as the basis for seeking payment from patients and third-party payers. The schedule of fees will be (i) designed to cover reasonable costs of providing services included in the approved scope of the project and (ii) consistent with locally prevailing rates or charges.
To assure that fees are set to cover reasonable costs and are consistent with locally prevailing rates or charges for the services, FHCW establishes its schedule of fees through the following process:
A. Services. FHCW determines the schedule of health center services that will have distinct fees. For example, the fee for a medical visit may differ from the fee for a dental visit.
B. Reasonable costs. FHCW determines the actual costs for providing the services for which there will be a separate fee.
C. Locally prevailing rates or charges. FHCW researches, reviews, and determines charges used by other healthcare providers in the community for the same or similar services.

FHCW will adjust the schedule of fees, as appropriate, based on regular cost analyses and changes in the local market. FHCW's Board must approve all adjustments to the schedule of fees.

DISCOUNT SCHEDULE GUIDELINES

1. Notification: FHCW will notify patients of the Sliding Fee Discount Program (SFDP) by:
   - An intake packet that includes the Sliding Fee Discount Program application and notification is made available to all uninsured patients at the time of service.
   - FHCW places the SFDP notification in the clinic waiting area.

2. All patients seeking healthcare services at FHCW are assured that they will be served regardless of their ability to pay. No one is refused service because of a lack of financial means to pay.

3. Request for Discount: Requests for discounted services may be made by patients, family members, social services staff, or others aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for clinic visits. Information and forms can be obtained from the Front Desk and Registration Desks.

4. Alternative Payment Sources: All alternative payment resources must be exhausted, including all third-party payments from insurance(s), Federal and State programs.

5. Completion of Application: The patient/responsible party must complete the Sliding Fee Discount Program application. By signing the Sliding Fee Discount Program application, persons authorize FHCW access to confirm income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in revoking all Sliding Discount Program discounts and the total balance of the account(s) restored and payable immediately.

   Suppose an application cannot be processed due to the lack of additional information. In that case, the applicant has two weeks from the date of notification to supply the necessary information without adjusting the date on their application. If a patient does not provide the requested information within the two weeks given, the application will be re-dated using the date of resubmission. Any invoice submitted for collection due to the patient's delay in providing information will not be considered for the Sliding Fee Discount Program.

6. **Eligibility for Discounts**
   Discount eligibility will be based solely on income and family size under the Department of Health and Human Services annual Federal Poverty Guidelines. No discounts under FHCW sliding fee discount program are provided to individuals/families with annual incomes above 200% of the FPG.

   Income shall be defined to include the following: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.

   Family shall be defined as a group of two people or more (one of whom is the head of household) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered members of one family. Family size is defined as the head of household, spouse, and dependents with proof of income for all family members/individuals living in the home or individuals for whom you are financially responsible.

7. **Waiving of Charges:** In certain situations, patients may be unable to pay the discounted fee. The waiving of charges may only be used in particular circumstances and must be approved by FHCW's CEO, CFO, COO, or their designee. Any waived charges must be documented in the patient's file along with an explanation (e.g., ability to pay, goodwill, health promotion event). These situations may include:

   a. Natural or artificial disasters (flood, fire, etc.)
   b. Catastrophic medical event or illness
   c. Victim of Violent Crime/Domestic Abuse
   d. Unaffordable Prescription Costs
      i. Large deductible
      ii. In the "Donut Hole"
      iii. High Copay Amounts

8. **Refusal to Pay:** If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient's charges will be posted on their account. If the patient does not make an effort to pay the bill within 120 days, this constitutes a "refusal to pay," and the amount will be reviewed and deemed uncollectible. Please refer to the Bad Debt/Self-Pay Policy.

9. FHCW makes reasonable efforts to collect payments owed from patients (See Billing and Collections Policy for additional information).

10. Recordkeeping: The electronic health record will maintain and preserve information related to Sliding Fee Discount Program decisions.

PROCEDURES

Patients who present as" self-pay" or complete an application for SFSD, including those with third-party coverage, will be referred to a Health Benefits Advisor (HBA) or Patient Accounts representative for assistance. The HBAs/PA reps will screen patients for eligibility, process applications, monitor usage, and report findings. Proof of family/household size and income is required to receive a discount under the SFSD. If the patient refuses or cannot furnish the accepted documents listed (Attachment A-5), they must sign a self-declaration report. (Attachment A-4).

Screening Process

1. Health Benefits Advisors will assist patients in determining eligibility for MassHealth, state-subsidized products, or the state's Health Safety Net program.
2. If the patient is ineligible/partially eligible for state programs, or if the patient opts not to enroll in the state program, and the patient's income does not exceed 200% of the FPL as outlined in the sliding fee scale (see Attachment A-2), the patient may apply for the SFSD (see Attachment A-3).

Sliding Fee Scale Application Process

1. Patients complete an application for SFSD (see Attachment A-3) providing their Name, Date of Birth, Address, Family (Household)Size, and proof of income; providing requested documentation to support data submitted (see list in Attachment A-5).
2. HBA enters family/household size and income level in the Uniform Data System (UDS) tab within a designated section of EHR (electronic health record) and/or PMS (Practice Management System) and verifies eligibility for the SFSD uniformly for all patients in the following manner.
3. Eligibility level is determined and classified into the following categories:

<u>Medical, Behavioral Health, Services:</u>

a. 0-100% of FPL $10.00 nominal fee
b. 101-133% of FPL 20% of full charge
c. 134-166% of FPL 40% of full charge
d. 167-200% of FPL 60% of full charge

<u>Dental Services:</u>

a. 0-100% $40.00 nominal fee per visit plus the cost of supplies and labs
b. 101-133% 20% of full charge per visit plus the cost of supplies and labs
c. 134-166% 40% of full charge per visit plus the cost of supplies and labs
d. 167-200% of FPL 60% of full charge p

Dental Exclusions: Patients will be responsible for the cost of supplies, and the labs' payment plan will be offered for patient responsibility.

<u>Pharmacy:</u>

a. 0-100% no charge
b. 101-133% $10.00 fee
c. 134-166% $20.00 fee
d. 167-200% $25.00 fee

The Pharmacy will generate a list of sliding fee patients with the appropriate sliding fee classification every week. The patient will pay the prescription cost if it is less than the SFSD fee. HBA updates the sliding fee scale page and insurance screen in the designated area of the EHR/PMS to reflect the type of scale the patient falls under and the effective/expiration dates, if eligible, as determined by the application process.

4. Application signed consent form and supporting documentation is retained by HBA and filed for future reference.
5. Patients are informed that if there are any changes in their family status, including family size, income changes, and health insurance coverage, they must notify FHCW as soon as possible.
6. A patient's eligibility for the SFSD is valid for one year from the date of application.
7. Hardship Waivers- Patients may seek to adjust charges based on their ability to pay due to hardship such as fire or incarceration. Patients requesting a waiver will be asked to complete (with staff assistance if needed) an application for consideration of the FHCW Hardship Waiver.

Check-in Process

Check-in staff in each location will assess/re-assess income and number in family/household at least once a year. It is part of the registration and check-in workflow to ask patients if there have been any changes to their income at every visit. Additionally, HBAs conduct annual verification of the household number and income.

1. Insurance coverage via MMIS, TriZetto, or payer websites at each visit.
2. If active insurance coverage is not found and the Federal Sliding Payer is not active in the patient's chart, the patient can apply for the SFSD and is referred to an HBA or patient accounting.
3. If active insurance is found and is eligible for a sliding-fee discount, patient charges are no more than they would have paid under the applicable SFDS discount pay class. This is subject to FHCW complying with state and payer contractual restrictions.
4. If the patient is eligible for the SFSD, the appropriate Sliding Fee Payer class type will be chosen within the EHR/PMS and attached to the visit. The proper sliding fee discount will be applied before sending a statement to the patient. Applicable co-payments, if any, will be collected.
5. If the patient has become ineligible for a discount, staff will refer the patient to an HBA for reapplication. The visit is entered as "self-pay," and the patient is reminded that they may receive a bill if reapplication is not completed with an HBA following the appointment.

MISCELLANEOUS:

1. The FHCW HBAs shall inform all patients about the availability of the SFSD during the new patient registration process. The FHCW will post signage to inform patients of the sliding fee scale (see Attachment A-2) and the availability of discounts on charges through the sliding fee scale and state agencies. Additional collateral (e.g., brochures) will be available to supplement the information outlined in the signage.
2. A copy of the FHCW's fee schedule and corresponding discounted patient amounts for the sliding fee scale and the Commonwealth of Massachusetts Health Safety Net assistance is maintained in our administrative offices for patient reference.

Attachment A-1

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family	**Poverty guideline**
1	$15,060
2	$20,448
3	$25,824
4	$31,200
5	$36,588
6	$41,964
7	$47,340
8	$52,728
For families/households with more than 8 persons, add $5,388 for each additional person.	

*Source: US Department of Health and Human Services, available at*Program financial guidelines for certain MassHealth applicants and members | Mass.gov *accessed on March 13, 2024*

Section 330 of the Public Health Service (PHS.) Act (42 USC §254b) available at: http://uscode.house.gov/view.xhtml?edition=prelim&req=42+usc+254b&f=treesort&fq=true&num=20&hl=true, accessed on March 13, 2024, via http://bphc.hrsa.gov/programrequirements/

Attachment A-2

Family Health Center of Worcester

Federal Sliding Fee Scale

Effective: January 01, 2024

WHO CAN QUALIFY

The sliding fee scale is a discount of charges for those who either have no insurance or who have insurance but have a high deductible or co-payment. It is also for people whose insurance does not cover services that may be necessary. Regardless of whether the patient has insurance or not, they must still meet the income guidelines to receive a discount. The sliding fee is a formula used to determine the availability of reduced charges to patients who qualify according to the number of individuals in the family and the average yearly income of the family.

HOW TO READ THE SLIDING FEE SCALE

Step 1: Locate the column corresponding to the number of individuals in your family or household.

Step 2: Move from the top to the bottom of the column to find the range containing your combined average annual income.

Step 3: Go to the item under the column to find the co-payment amount you will need to pay per visit.

Family Size	0-100% of FPL	101-133% of FPL	134-166% of FPL	167-200% of FPL	0-100% of FPL
Size	Income Level Between	Income Level Between	Income Level Between	Income Level Between	Income Level Between
1	$0 15,670	15,671 20,040	20,041 25,000	25001 30,120	$30,121 ore more
2	$0 20,448	20,449 27,192	27,193 33,930	33,931 40,884	$40,885 ore more
3	$0 25,824	25,825 34,344	34,345 42,861	42,862 51,648	51,649 ore more
4	$0 31,200	31,201 41,496	41,497 51,792	51,793 62,400	62,401 ore more
5	$0 36,588	36,589 48,660	48,661 60,723	60,724 73,164	73,165 ore more
6	$0 41,964	34,965 55,812	55,813 69,654	69,655 83,928	83,929 ore more
7	$0 47,340	47,341 62,964	62,965 78,584	78,585 94,680	94,681 ore more
8	$0 52,728	52,729 70,128	70,129 87,515	87,516 105,444	105,445 ore more
	You Pay	You Pay	You Pay	You Pay	You Pay
Medial, BH	$10 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full charge
Vision					
Dental*	$40 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full charge
Optical	$0 Basic, cost all others	$10 Basic, cost all others	$25 Basic, cost all others	$40 Basic, cost all others	Full charge
Pharmacy	No charge	$10	$20	$25	Full charge

*** Dental Exclusions: Patients will be responsible for the cost of supplies and labs; a payment plan will be offered for patients responsibility.**

†*Individuals with income levels over two hundred percent (200%+) may be eligible for financial assistance through the Health Safety Net for Office Visits and Dental Services.*

Attachment A-3

SLIDING FEE SCALE DISCOUNT APPLICATION

If you wish to qualify for the sliding fee scale discount, you MUST show proof of income for all family members/individuals living in your household or individuals for whom you are financially responsible. If you do not have any source of income, please speak with a staff member. Applicants should provide a copy of either:

- Two consecutive pay stubs for each employed adult age 18 and over living in the household or living outside the household but for whom the household is financially responsible, OR
- Previous year's tax return or W-2 for each adult living in the household or for whom the household is financially responsible income will come from the Adjusted Gross Income line on the respective tax return).

_____ _____ _____ /_____ /_____

Name Phone Number Date of Birth

_____

Address City State ZIP Code

List name(s) and date(s) of birth of family members/individuals living in your household or individuals for whom you are financially responsible.

1. _____ 2. _____

2. _____ 4. _____

5._____ 6. _____

7._____ 8. _____

DISCLAIMER: I hereby certify under the pains and penalties of perjury that the above information is, to the best of my knowledge, true and correct. I further agree to notify Family Health Center of Worcester of any changes in this information. I understand that I must re-qualify annually to maintain my eligibility. I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government. Sliding Fee payment is due and payable at the time of service. To maintain a discount, fees must be paid promptly. If you are unable to make payment at the time of service, please speak with the receptionist to make other arrangements.

_____ _____ /_____ /_____

Signature Date

DETERMINING ELIGIBILITY: Family Health Center of Worcester, Inc. is a Federally Qualified Health Center. We are able to offer a discount on some services based on a household's income and size. Sliding fee calculations are determined by using Federal Income Tax forms, W-2's, or last two consecutive pay stubs. The staff at FHCW then uses the table below to determine your eligibility. Your household discount will be assessed on a yearly basis. Individuals who are visiting the United States, including those who are visiting for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, do not meet the residency requirements for the federal sliding fee discount.

PLEASE NOTE: There is a minimum charge for some procedures and dental lab fees.

***Exclusions:** Exclusions to the sliding fee discounts include the cost of certain supplies, Dental labs fees and hospital/nursing home services.

Financial assistance may be available: *Depending upon your income level and family size, you may qualify for financial assistance with your healthcare services.*

Family Size Size	0-100% of FPL Income Level Between		101-133% of FPL Income Level Between		134-166% of FPL Income Level Between		167-200% of FPL Income Level Between		0-100% of FPL Income Level Between	
1	$0	15,670	15,671	20,040	20,041	25,000	25001	30,120	$30,121	ore more
2	$0	20,448	20,449	27,192	27,193	33,930	33,931	40,884	$40,885	ore more
3	$0	25,824	25,825	34,344	34,345	42,861	42,862	51,648	51,649	ore more
4	$0	31,200	31,201	41,496	41,497	51,792	51,793	62,400	62,401	ore more
5	$0	36,588	36,589	48,660	48,661	60,723	60,724	73,164	73,165	ore more
6	$0	41,964	34,965	55,812	55,813	69,654	69,655	83,928	83,929	ore more
7	$0	47,340	47,341	62,964	62,965	78,584	78,585	94,680	94,681	ore more
8	$0	52,728	52,729	70,128	70,129	87,515	87,516	105,444	105,445	ore more

	You Pay	You Pay	You Pay	You Pay	You Pay
Medial, BH	$10 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full charge
Vision					
Dental*	$40 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full charge
Optical	$0 Basic, cost all others	$10 Basic, cost all others	$25 Basic, cost all others	$40 Basic, cost all others	Full charge
Pharmacy	No charge	$10	$20	$25	Full charge

*** Dental Exclusions: Patients will be responsible for the cost of supplies and labs; a payment plan will be offered for patient's responsibility.**

Return completed application to: 26 Queen Street, Worcester, MA 01610

For more information, please see a Health Benefit Advisor at the Family Health Center of Worcester (1st Floor Main Lobby) or call 508-860-7700.

FOR OFFICE USE ONLY

Eligibility Date:_____ Renewal/Termination Date:_____

Attach income documentation: ❒ Pay stub(s) ❒ Tax Form(s) ❒ Other _____

Federal Sliding Fee Scale Category:

		Medical BH Vision	Dental	Optical	Pharmacy
0-100% of FPL	❒	$10.00 nominal fee	$40 of full chg	$0 Basic; cost all others	No Charge
101-133% of FPL	❒	20% of full charge	20% of full chg	$10 Basic; cost all others	$10
134-166% of FPL	❒	40% of full charge	40% of full chg	$25 Basic; cost all others	$20
167-200% of FPL	❒	60% of full charge	60% of full chg	$40 Basic; cost all others	$25

*Exclusions to the sliding fee discounts include the cost of some dental supplies and hospital/nursing home services.

Application processed/approved by:_____ Date:_____

Attachment A-4 ANNUAL SELF-DECLARATION OF INCOME REPORT

Federal regulations require that we obtain this information annually in order to document that we are serving low- and moderate-income households. The Participant/Guardian should complete this form including all persons residing in their household, regardless of whether or not they are related. The information in this report will be retained for the purposes of the aggregate reporting.

INFORMATION PROVIDED ON THIS FORM IS KEPT CONFIDENTIAL AND IS NOT SHARED WITHOUT YOUR PERMISSION EXCEPT AS REQUIRED BY LAW TO CONFIRM INCOME ELIGIBILITY OF PARTICIPANTS IN FUNDED PROGRAMS.

PARTICIPANT INFORMATION

PARTICIPANT STATUS: [ ] FAMILY [ ] INDIVIDUAL

Participant Name: _____

Residential Address: _____

ETHNICITY (please select only one) :

[ ] Hispanic or Latino [ ] Not Hispanic or Latino

RACE (please select only one) :

[ ] White
[ ] Black/African American
[ ] Asian
[ ] American Indian/Alaskan Native
[ ] Native Hawaiian/Other Pacific Islander
[ ] American Indian/Alaskan Native *and* White
[ ] Asian *and* White
[ ] Black/African American *and* White
[ ] American Indian/Alaskan Native *and* Black/African American
[ ] Other Multi-Racial: _____

HOUSEHOLD INFORMATION

1) Circle the number of family and non-family members living in your household below.

2) Circle the corresponding annual household income level.

Family Size Size	0-100% of FPL Income Level Between		101-133% of FPL Income Level Between		134-166% of FPL Income Level Between		167-200% of FPL Income Level Between		0-100% of FPL Income Level Between	
1	$0	15,670	15,671	20,040	20,041	25,000	25001	30,120	$30,121	ore more
2	$0	20,448	20,449	27,192	27,193	33,930	33,931	40,884	$40,885	ore more
3	$0	25,824	25,825	34,344	34,345	42,861	42,862	51,648	51,649	ore more
4	$0	31,200	31,201	41,496	41,497	51,792	51,793	62,400	62,401	ore more
5	$0	36,588	36,589	48,660	48,661	60,723	60,724	73,164	73,165	ore more
6	$0	41,964	34,965	55,812	55,813	69,654	69,655	83,928	83,929	ore more
7	$0	47,340	47,341	62,964	62,965	78,584	78,585	94,680	94,681	ore more
8	$0	52,728	52,729	70,128	70,129	87,515	87,516	105,444	105,445	ore more

By signing this application, I certify that the submissions and statements I have made in this application are true and complete to the best of my knowledge,

Participant/Guardian: _____ Date: _____

Attachment A-5 ID Proofing and Income Verification Accepted Documents

ID Proofing Accepted Documents

- Driver's license issued by state or territory
- School identification card
- Voter Identification card
- military draft card or draft record
- Identification card issued by the federal, state, or local government
- US passport or US passport card
- Certificate of Naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561)
- U.S. Customs I-94 Arrival/Departure Record; Nonimmigrant Visa Waiver/Immigration Travel Documents
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Employment Authorization Document that contains a photograph (Form I-766)
- Military dependent's identification card
- Native American Tribal document
- Coast Guard Merchant Mariner card
- Foreign passport, or identification card issued by a US-Based foreign embassy or consulate that contains a photograph

Or <u>two</u> of the following documents instead:

- Birth certificate
- Social Security card
- Marriage certificate
- Divorce decree
- Employer identification card
- High school or college diploma (including high school equivalency diplomas)
- Property deed or title

Income

- Your most recent Form 1040 (US Individual Income Tax Return) with all attachments including W2s

- Recent pay stubs, at least 2 consecutives
- A signed earnings statement from your employer
- If you are seasonally employed, any of the proofs above including information about the duration of your employment
- Self-employment ledger
- 1099-MISC and your most recent Form 1040 (US Individual Income Tax Return) with all attachments
- Military Leave and Earnings statement
- Agricultural income certificate
- 1040 SE with Schedule C, F, or SE (for self-employment income)
- Bookkeeping records
- Signed and dated most recent quarterly or year-to-date profit and loss statement
- Proof of residuals
- Cost of living adjustment letter and other benefit verification notices
- Document or letter from Social Security Administration (SSA.)
- Form SSA 1099 Social Security benefits statement
- Recent court records for alimony and records of agency through which alimony is paid
- Recent legal documents that establish amount and frequency of alimony
- Letter from government agency for unemployment benefits
- Proof of tribal income
- 1099-G and your most recent Form 1040 (US Individual Income Tax Return) with all attachments

Attachment A-6

Hardship Waiver Form

Responsible Party's Name:_____ Patient Acct#:_____

Current Balance:_____ Sliding Fee Discount:_____

Eligibility criteria that may be considered include fire, homelessness and/or incarceration for >18 mos.

Please indicate the reason(s) for this hardship waiver request._____

Verification: Attach documentation or any written attestations demonstrating eligibility.

By signing, I certify that I understand that I am applying for a Hardship Waiver consideration on balances due to Family Health Center of Worcester.

OFFICE USE ONLY

Sliding Fee Schedule:_____ Hardship Waiver Status:_____

Current Monthly Household Income:_____ Amount of Discount:_____

Family Size:_____ Comment:_____

Director of Patient Accounts_____ Chief Executive Officer:_____
Signature Signature