


Policy #: 2402	Policy Title: Federal Sliding Fee Scale
Department: Finance	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, 02/18/25, 02/17/25, 03/18/26
Original Author: S. Burke Effective Date: 11/03	
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). 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 their 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 the 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 ensure 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 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 the 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 the FHCW sliding fee discount program are provided to individuals/families with annual incomes above 200% of the FPL.

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 one or more persons living together who are related by birth, marriage, adoption, legal guardianship, or domestic partnership, or who demonstrate financial interdependence. Family size includes the head of household, spouse or partner, dependents, and any individuals for whom the applicant is financially responsible. Proof of income may be required for all applicable household members whose income contributes to the household.

- 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 certain 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
- e. Transitional hardship related to incarceration or reentry into the community, including loss of income, insurance disruption, housing instability, or inability to access medically necessary care or medications.

FEE WAIVER REQUEST

The health center recognizes that certain patients may experience extraordinary or temporary financial hardships that affect their ability to pay for services. In such circumstances, patients may request a waiver of all or a portion of their outstanding fees. Fee waivers are granted on a case-by-case basis and are not automatic.

a. Eligibility for Fee Waiver

A fee waiver may be considered when a patient demonstrates a significant financial hardship resulting from one or more of the following circumstances, including but not limited to:

- Experiencing homelessness or housing instability
- A natural disaster or other catastrophic event
- Long-term hospitalization or serious illness
- Inability to access personal or household funds

- Intimate partner violence or domestic violence
- Job loss or other sudden loss of income
- Divorce or legal separation resulting in financial hardship
- Large or unexpected medical bills

Eligibility for a fee waiver is separate from, and does not replace, eligibility for the Sliding Fee Discount Program.

b. Fee Waiver Request Process

1. Patient Request

- A patient requesting a fee waiver must submit a written request in the form of a letter addressed to the **Chief Financial Officer (CFO)**.
- The letter must explain the patient's financial situation, the circumstances leading to the hardship, and the specific request for a waiver of fees.
- Supporting documentation may be requested when appropriate, but is not required in all cases.

2. Review and Determination

- The CFO reviews each fee waiver request individually, considering the circumstances described and any supporting information provided.
- The CFO may approve, partially approve, or deny the request based on the facts presented and applicable health center policies.

3. Notification of Decision

- If the fee waiver is approved (in whole or in part), the CFO or designee will contact the patient to notify them of the decision.
- Approved waivers will be scanned into the patient's electronic medical record in the media center.
- CFO informs the billing company of the approved waiver, and the billing staff makes the necessary adjustments to the balance.
- If a request is denied, the patient may be informed of alternative options, including payment plans or reassessment for sliding fee eligibility.

c. Documentation and Recordkeeping

All fee waiver requests and determinations will be documented and maintained in accordance with record retention and confidentiality requirements. Fee waivers will be applied consistently and in a manner that supports transparency and compliance with federal requirements.

d. Non-Retaliation and Access to Care

Requesting a fee waiver will not result in retaliation, denial of care, or reduced access to services. Patients may continue to receive medically necessary services regardless of the outcome of a fee waiver request, consistent with federal FQHC requirements.

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

9. 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:

Medical, Behavioral Health, and Laboratory Services:

- | | |
|--------------------|---------------------|
| 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 |

Dental Services:

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

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

Pharmacy:

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

Family Planning and Reproductive Health Services

The Sexual and Reproductive Health (SRH) program requirements for discounting services include the requirement to extend discounts to patients who fall between 200-250% of the Federal Poverty Guidelines. As such, FHCW has included a 4th discount class to apply only to family planning and reproductive health services. Those services include:

1. Contraceptive services and related counselling

2. Pregnancy Testing and related counselling
3. Assisting patients who want to conceive
4. Basic infertility services
5. Screening and treatment for sexually transmitted diseases
 - 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
 - e. 201-250% of FPL 80% of full charge
4. Application signed consent form and supporting documentation are 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

2026 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family	Poverty guideline
1	\$15,960
2	\$21,640
3	\$27,320
4	\$33,000
5	\$38,680
6	\$44,360
7	\$50,040
8	\$55,720

For families/households with more than 8 persons, add \$6,880 for each additional person.

Source: Office of The Assistant Secretary For Planning and Evaluation, available at <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines> accessed on February 16, 2026

Section 330 of the Public Health Service (PHS.) Act (42 USC §254b) available at: [42 USC 254b: Health centers](#) accessed on February 16, 2025, via [Chapter 9: Sliding Fee Discount Program Bureau of Primary Health Care](#)

Attachment A-2



Federal Sliding Fee Scale

Effective: January 01, 2026

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	201+% of FPL	201-250% of FPL (TitleX/SRH Services Only)
	Income level between:	Income level between:	Income level between:	Income level between:	Income level between:	Income level between:
1	\$0 \$15,960	\$15,961 \$21,227	\$21,228 \$26,494	\$26,495 \$31,920	\$31,921 or more	\$31,301 \$39,900
2	\$0 \$21,640	\$21,641 \$28,781	\$28,782 \$35,922	\$35,923 \$43,280	\$43,281 or more	\$42,301 \$54,100
3	\$0 \$27,320	\$27,321 \$36,336	\$36,337 \$45,351	\$45,352 \$54,640	\$54,641 or more	\$53,301 \$68,300
4	\$0 \$33,000	\$33,001 \$43,890	\$43,891 \$54,780	\$54,781 \$66,000	\$66,001 or more	\$64,301 \$82,500
5	\$0 \$38,680	\$38,681 \$51,444	\$51,445 \$64,209	\$64,210 \$77,360	\$77,361 or more	\$75,301 \$96,700
6	\$0 \$44,360	\$44,361 \$58,999	\$59,000 \$73,638	\$73,639 \$88,720	\$88,721 or more	\$86,301 \$110,900
7	\$0 \$50,040	\$50,041 \$66,553	\$66,554 \$83,066	\$83,067 \$100,080	\$100,081 or more	\$97,301 \$125,100
8	\$0 \$55,720	\$55,721 \$74,108	\$74,109 \$92,495	\$92,496 \$111,440	\$111,441 or more	\$108,301 \$139,300

	0-100% of FPL	101-133% of FPL	134-166% of FPL	167-200% of FPL	201+% of FPL	201-250% of FPL (TitleX/SRH Services Only)
You Pay						
Medical, BH & Lab	\$10 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full Charge †	80% of full charge
Dental*	\$40 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full Charge †	80% of full charge
Pharmacy	No Charge	\$10	\$20	\$25	Full Charge †	\$30

*Dental Exclusions: Patients will be responsible for the cost of supplies and labs; a payment plan will be offered for patient 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.
 ‡ Patients with income between 201%–250% FPL may qualify for discounted rates for SRH services only in accordance with Title X funding requirements

Nominal Fees: Medical, Behavioral Health nominal fees are \$10 and \$40 for dental services, (\$10 to \$30) for pharmacy

- The flat nominal fee does not reflect the actual cost of the service being provided.
- Nominal fee is applied to patients who qualify for full discount unless the amount represents a fee higher than would be paid by a patient in the first sliding fee discount pay class above 100%. In that case, the nominal fee would be waived.

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

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.

Family Size	0-100% of FPL	101-133% of FPL	134-166% of FPL	167-200% of FPL	201+% of FPL	201-250% of FPL (TitleX/SRH Services Only)
	Income level between:	Income level between:	Income level between:	Income level between:	Income level between:	Income level between:
1	\$0 \$15,960	\$15,961 \$21,227	\$21,228 \$26,494	\$26,495 \$31,920	\$31,921 or more	\$31,301 \$39,900
2	\$0 \$21,640	\$21,641 \$28,781	\$28,782 \$35,922	\$35,923 \$43,280	\$43,281 or more	\$42,301 \$54,100
3	\$0 \$27,320	\$27,321 \$36,336	\$36,337 \$45,351	\$45,352 \$54,640	\$54,641 or more	\$53,301 \$68,300
4	\$0 \$33,000	\$33,001 \$43,890	\$43,891 \$54,780	\$54,781 \$66,000	\$66,001 or more	\$64,301 \$82,500
5	\$0 \$38,680	\$38,681 \$51,444	\$51,445 \$64,209	\$64,210 \$77,360	\$77,361 or more	\$75,301 \$96,700
6	\$0 \$44,360	\$44,361 \$58,999	\$59,000 \$73,638	\$73,639 \$88,720	\$88,721 or more	\$86,301 \$110,900
7	\$0 \$50,040	\$50,041 \$66,553	\$66,554 \$83,066	\$83,067 \$100,080	\$100,081 or more	\$97,301 \$125,100
8	\$0 \$55,720	\$55,721 \$74,108	\$74,109 \$92,495	\$92,496 \$111,440	\$111,441 or more	\$108,301 \$139,300

	0-100% of FPL	101-133% of FPL	134-166% of FPL	167-200% of FPL	201+% of FPL	201-250% of FPL (TitleX/SRH Services Only)
	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay
Medical, BH & Lab	\$10 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full Charge†	80% of full charge
Dental*	\$40 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full Charge†	80% of full charge
Pharmacy	No Charge	\$10	\$20	\$25	Full Charge†	\$30

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

‡ Patients with income between 201%–250% FPL may qualify for discounted rates for SRH services only in accordance with Title X funding requirements

Nominal Fees: Medical, Behavioral Health nominal fees are \$10 and \$40 for dental services, (\$10 to \$30) for pharmacy

- The flat nominal fee does not reflect the actual cost of the service being provided.
- Nominal fee is applied to patients who qualify for full discount unless the amount represents a fee higher than would be paid by a patient in the first sliding fee discount pay class above 100%. In that case, the nominal fee would be waived.

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:

		<u>Medical BH Lab</u>	<u>Dental</u>	<u>Pharmacy</u>
0-100% of FPL	<input type="checkbox"/>	\$10.00 nominal fee	\$40 nominal fee	No Charge
101-133% of FPL	<input type="checkbox"/>	20% of full charge	20% of full charge	\$10
134-166% of FPL	<input type="checkbox"/>	40% of full charge	40% of full charge	\$20
167-200% of FPL	<input type="checkbox"/>	60% of full charge	60% of full charge	\$25
201%+ of FPL	<input type="checkbox"/>	Full charge	Full charge	Full charge
201-250% of FPL (SRH)	<input type="checkbox"/>	80% of full charge	80% of full charge	\$30

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

Application processed/approved by: _____ Date: _____

FOR OFFICE USE ONLY

Attach income documentation: Pay stub(s) Tax form(s) Other -----

Eligibility Date: ----- Renewal/Termination Date:-----

		<u>Medical/BH/Lab</u>	<u>Dental</u>	<u>Pharmacy</u>
0-100% of FPL	<input type="checkbox"/>	\$10.00 of nominal fee	\$40 of full charge	No charge
101-133% of FPL	<input type="checkbox"/>	20% of full charge	20% of full charge	\$10
134-166% of FPL	<input type="checkbox"/>	40% of full charge	40% of full charge	\$20
167-200% of FPL	<input type="checkbox"/>	60% of full charge	60% of full charge	\$25
201-250% of FPL	<input type="checkbox"/>	80% of full charge	80% of full charge	\$30

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

Application processed by: -----Date -----

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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 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 [] American Indian/Alaskan Native *and* White
 [] Black/African American [] Asian *and* White
 [] Asian [] Black/African American *and* White
 [] American Indian/Alaskan Native [] American Indian/Alaskan Native *and* Black/African American
 [] Native Hawaiian/Other Pacific Islander [] 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	0-100% of FPL	101-133% of FPL	134-166% of FPL	167-200% of FPL	201+% of FPL	201-250% of FPL (TitleX/SRH Services Only)
	Income level between:	Income level between:	Income level between:	Income level between:	Income level between:	Income level between:
1	\$0 \$15,960	\$15,961 \$21,227	\$21,228 \$26,494	\$26,495 \$31,920	\$31,921 or more	\$31,301 \$39,900
2	\$0 \$21,640	\$21,641 \$28,781	\$28,782 \$35,922	\$35,923 \$43,280	\$43,281 or more	\$42,301 \$54,100
3	\$0 \$27,320	\$27,321 \$36,336	\$36,337 \$45,351	\$45,352 \$54,640	\$54,641 or more	\$53,301 \$68,300
4	\$0 \$33,000	\$33,001 \$43,890	\$43,891 \$54,780	\$54,781 \$66,000	\$66,001 or more	\$64,301 \$82,500
5	\$0 \$38,680	\$38,681 \$51,444	\$51,445 \$64,209	\$64,210 \$77,360	\$77,361 or more	\$75,301 \$96,700
6	\$0 \$44,360	\$44,361 \$58,999	\$59,000 \$73,638	\$73,639 \$88,720	\$88,721 or more	\$86,301 \$110,900
7	\$0 \$50,040	\$50,041 \$66,553	\$66,554 \$83,066	\$83,067 \$100,080	\$100,081 or more	\$97,301 \$125,100
8	\$0 \$55,720	\$55,721 \$74,108	\$74,109 \$92,495	\$92,496 \$111,440	\$111,441 or more	\$108,301 \$139,300

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 dependents' 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 two 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 consecutive
- 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 the 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 the 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

Policy #: 2402	Policy Title: Federal Sliding Fee Scale
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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 months.

<p><u>Please indicate the reason(s) for this hardship waiver request.</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

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 _____ Signature	Chief Executive Officer: _____ Signature