Fetter Health Care
NETWORK

51 Nassau Street
Charleston, SC 29403
Phone (843) 722-4112
Fax (866) 285-7156

HOUSING / INCOME VERIFICATION

I, _____ receive $ _____ in monthly income.

I certify to the best of my knowledge that this information provided to Fetter Health Care Network (FHCN), is true and accurate. I understand that I am to immediately report any and all changes in income to the staff of Fetter Health Care Network and that falsification or failure to report income information may lead to my inability to receive medical services at Fetter Health Care Network.

Housing Information

Are you residing in a Shelter or Housing Program? Yes _____ No _____

If Yes:

Name of Shelter/Program: _____

Address of Shelter/Program: _____

If No:

Address _____

Number of Children _____ Number of Adults _____

_____ _____
Consumer's Signature Date

_____ _____
Case Mgr. / Employer / Head of Household Date

_____ _____
Witness/FHCN Representative Date

_____ _____
Shelter or Housing Notary Approval Date

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SLIDING FEE APPLICATION

It is the policy of Fetter Health Care Network to provide services regardless of an individual's inability to pay. Discounts are offered depending upon household income and family size. A **"family"** is one or more persons living in one dwelling place who are related by blood, marriage, or law. Adults and minor children are considered a family. **Relatives over 18 (that are not full time students) are not eligible to be used as dependents for this application process.** Please complete the following questions to determine if you or your family members are eligible for our sliding scale program.

Household Member's Name	**Date of Birth**	**Weekly**	**Monthly**	**Annual**	Date All Documentation Received	Documentation Received by
You:						
Spouse:						
Dependent:		X	X	X		
Dependent:		X	X	X		
Dependent:		X	X	X		
Dependent:		X	X	X		

The total number of family members living in your household (working and non-working):_____

Qualified Poverty Percentage	Medical Slide Category	Dental Slide Category	Slide Effective Date	Slide Termination Date

Note: Include income from all sources from Adults listed above. These include, but are not limited to: gross wages, tips, social security, disability, pensions, annuities, veterans' payments, net business or self-employment, alimony, child support, military, unemployment public aid and any other form of income.

All Information Will Be Kept Confidential

I certify that the above information is true and correct to the best of my knowledge. I am also aware that this information may be randomly audited at any time for verification purposes. Knowingly providing false information may result in termination of Sliding Fee Discount Program and/or termination of services at Fetter Health Care Network.

_____ _____
Signature of Applicant/Printed Name Date

_____ _____
Signature/Printed Name of Financial Eligibility Specialist Date of Interview

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Self-Declaration Form

Eligibility for Federal Poverty Sliding Fee Adjustment

Patient's: Name: _____

Patient's Data of Birth: _____

Patient's Address: _____

Patient's Telephone Number: _____

Reason for completing this form: □ Self-declaring annual household income and family size
□ Currently not working
□ Not receiving any type of benefits or income

_____ I further declare that no other family member is receiving income/benefits that would pay for services. I understand that when I or any other family members begins receiving any type of benefit, I must report this information to Fetter Health Care Network.

_____ I do not health insurance that will pay for my services. If it is later verified by a Fetter Health Care Network employee to be untrue, the Health Center reserves the right to bill the Insurance Company for all covered dates of services and the patient maybe recommended for dismissal from the health center.

_____ Annual Gross Income: $_____

_____ Family Size_____ (includes the mother, father, and dependent children under the age of 18)

I certify that the information that I provided is correct and I authorize the health center to use it. I understand that this information will be used to determine my eligibility for a Sliding Scale Discount, and if eligible, I will receive a temporary discount for health services for 30 days. I understand that I will be charged at 100% of the medical office visit or pharmacy prescriptions if I do not bring in proper documentations within 30 days.

Patients will not be able to reapply for participation on the Sliding Fee program until they bring in the required documentation for annual income and family size. Prior fees will not be adjusted. Patients will not be able to Self-Declare if completing a secondary application prior to their annual registration date.

I certify that the above information is true and correct to the best of my knowledge. I am also aware that this information may be randomly audited at any time for verification purposes. Knowingly providing false information may result in termination of Sliding Fee Discount Program and/or termination of services at Fetter Health Care Network.

_____ _____
Applicant Signature Date

_____ _____
Financial Eligibility Specialists Signature Date

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Sliding Fee Discount Program Acknowledgment Form

Fetter Health Care Network must have a Sliding Fee Discount Program (SFDP) which ensures that patients have use of all services in the health center, regardless of their ability to pay. Specifically, the sliding fee discount program must include the following:

(1) A listing of fees for services;

(2) A corresponding list of discounts for eligible patients that is adjusted based on the patient's ability to pay; and

(3) Board-approved policy and procedures, including those around billing and collections.

While the sliding fee discount program supports that patients can be monetarily invested in their care based on their ability to pay, it is intended to decrease financial burden to care for patients at or below 200 percent of the Federal Poverty Guidelines (FPG). Therefore, neither the fees themselves nor the supporting operating procedures for assessing patient eligibility and collecting payment should not care.

Please Initial:

_____ **I understand the Sliding Fee Discount Program and agree to complete the Sliding Fee application.**

_____ **I understand the Sliding Fee Discount Program and refuse to complete the Sliding Fee application**.

I understand my refusal to complete the Sliding Fee Scale Application means that you cannot be assessed for discount programs. Therefore you will be required to pay 100% for services provided by Fetter Health Care Network after any insurance payment and adjustment.

_____ _____

Patients' Name (Please Print) Date

_____

Patient's Signature

_____ _____

FHCN Employee's Signature Date