Fetter Health Care
NETWORK

Corporate Office:
51 Nassau Street
Charleston, SC, 29403
Phone:(843) 722-4112
Fax: (843) 722-5726

SLIDING FEE DISCOUNT PROGRAM APPLICATION

It is the policy of **Fetter Health Care Network (FHCN)**, to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. To comply with federal regulations, in order to give you a discount on our medical, dental, and Obstetrics prenatal services, it is necessary for us to ask some personal questions. Your answer will be kept on file and in strict confidence. You must verify your income at least every twelve (12) months. Please bring yearly income tax returns, last month's paycheck stubs, copies of your Social Security award letter, or other supported documents you may receive as proof of family income. Only the family size and annual growth income will be used to determine your eligibility and calculate your discount. I understand that I may be required to complete a work statement recertification form. Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at FHCN. This form must be completed every 12 months or if your financial situation changes.

HEAD OF HOUSEHOLD INFORMATION

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Place of Employment: _____

Home Phone: _____ **Cell Phone:** _____ **Other:** _____

Email: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

PLEASE LIST SPOUSES, DEPENDENTS UNDER AGE 18, AND OTHER HOUSEHOLD MEMBERS.

	Name	DOB		Name	DOB
Self			Dependent		
Spouse/ Partner			Dependent		
Dependent			Dependent		
Dependent			Dependent		
Household Member			Household Member		

ANNUAL HOUSEHOLD INCOME

Income Source	Self	Spouse/ Partner	Other	Total
□**Daily** □**Weekly** □ **Bi-Weekly** □ **Monthly** □ **Annually**				
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplement Security Income, public assistance, veterans' payment, survivor benefits, pension, or retirement income				
Interest, dividends, rent royalties, income for estate, trust, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.				
Total income				

Note: Copies of tax returns, pay stubs, or other information verifying income will be required before a discount is approved.

I certify that the family size and income information shown above are correct. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program. If accepted to the sliding fee program obtained under this application, I will comply with all rules and regulations of Fetter Health Care Networks medical, dental, and OB/ Prenatal programs.

Name of Patient _____ Date: _____

Signature of Patient or Guardian _____ Date: _____

Revised 01/21/2023

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As a community healthcare center, Fetter Health Care Network offers a sliding fee discount to all patients. This benefit can help to lower the cost of medical and dental services provided by Fetter Health Care Network and make medications more affordable at our pharmacy. Any patient, with or without insurance, can apply and qualification is based on income and household size. If you are interested in completing an application or would like more information, please take a moment to view the table below to see if you may qualify. I would like more information about the sliding fee program.

☐ Yes ☐ No (if no state reason): _____

Medical		
Categories	**Fee**	**If determined that other labs are needed based on the patient's diagnosis further charges will be discussed with the patient.**
100% Poverty	$30	
101%- 133% Poverty	$35	
134%- 150% Poverty	$40	
151%- 200% Poverty	$50	
> 200%	**No Sliding Fee Scale Discount**	

Dental			
Categories	**Fee (age 2-17 years old)**	**Fee (age 18+)**	**If determined that oral hygiene is not in basic treatment, an alternative treatment will be discussed with the patient. Fluoride varnish will be provided during children's visits at an additional cost for 18+. If additional X-Rays are deemed necessary, the cost will be discussed with the patient.**
100% Poverty	$50	$50	
101%- 133% Poverty	$60	$60	
134%- 150% Poverty	$70	$70	
151%- 200% Poverty	$80	$80	
> 200%	$100	$100	

OB/ Parental			
Categories	**Fee Initial visit**	**Fee Return Visits**	**If determined that other labs are needed based on the patient's diagnosis or the patient's trimester further charges will be discussed with the patient**
100% Poverty	$180	$65	
101%- 133% Poverty	$185	$70	
134%- 150% Poverty	$190	$75	
151%- 200% Poverty	$195	$80	
> 200%	$200	**No Sliding Fee Scale Discount**	

Pharmacy			
Categories	**30 Days Supply**	**90-Days Supply***	**The patient must schedule an appointment with Patient Navigator to complete Well Vista Application within 15 days of receiving the discount.**
100% Poverty	$0.00-$3.00	$0.00-$9.00	
75% Poverty	$3.01-$8.00	$9.01-$18.00	
50% Poverty	$8.01-$16.00	$18.01-$27.00	
25% Poverty	$16.01-$24.00	$27.01-$36.00	
0%	**No Sliding Fee Scale Discount**	**No Sliding Fee Scale Discount**	

I understand by selecting NO above, I am responsible for the full payment of medical, dental, Obstetrics Parental, and Pharmacy services. I will also be required to pay for the medications filled at the Fetter Health Care Network Pharmacy.

I authorize the release of information regarding the continuation of care and/or any payments for services. I authorize a copy of the document may be used as the original document. I certify that this information is true and correct to the best of my ability.

Print Name:

Signature:

Date:

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FINANCIAL AND APPOINTMENT AGREEMENT

Sliding Fee Discount Program

Based on the household and income information provided by the patient, the category will be:

Poverty:

☐ **100%** ☐ **101%- 133%** ☐ **134%- 150%** ☐ **151%- 200%** ☐ **200%**

Payment Expectations

Fetter Health Care Network provides many options for patients to minimize the financial barriers to healthy, and complete care. As a courtesy, the office staff will file for all insurance including Medicaid and Medicare. However, you will be expected to pay your estimated copay at the time of service. If your insurance or Medicaid or Medicare does not pay for part or all of the services, you are responsible for the balance. We realized that a temporary financial situation may affect the timely payments of your accounts. If such a problem does arise, we encourage you to contact us promptly for assistance and management of your account.

Scheduling, Canceling, and No-Show for appointments

FHCN expected that you will check in twenty (20) minutes prior to your scheduled appointment time. Patients that arrive fifteen (15) minutes late for scheduled appointments will be asked to wait in the lobby while the Front Desk staff reviews the provider schedule for availabilities to determine if the patient can be seen at the time or at a later time. To accommodate patients that arrive late for the scheduled appointment may be seen by another Provider. An appointment must be canceled at least 24 hours prior to the time of the appointment or will be considered a “No- Show”. After three no-shows patients will be charged a fee of $5. A fee of $10 will be charged for each No- Show scheduled dental procedure.

Specialty referral

Your treatment may require services that cannot be provided at Fetter Health Care Network. In this case, you will be referred to another specialist for the completion of your treatment. Payment agreements must be made with the specialist office prior to your first visit. Sliding fees may not apply to outside providers.

Name of Patient _____ Date: _____

Signature of Patient or Guardian _____ Date: _____