Lorain County Health & Dentistry

How to apply for the Sliding Fee Scale (SFS) Discount

1. Call (440) 240-1655 to make an appointment with a Billing Associate
2. Bring the following documents to your SFS appointment
    a. Photo ID
    b. Proof of income for everyone in your household

- **Who is included in the household**

Do Include:

- Yourself
- Your Spouse
- Your children under 19 who live with you and their children who also live with you (if employed please provide their proof of income)
- Your unmarried partner IF you have a common child together that resides in the household
- Anyone else under 19 that lives with you if you are their legal guardian and have proper documentation
- Your children 19-26 who live with you and are full time students (living at the school campus is considered “living with you”) (provide documentation of school enrollment)

Do NOT Include

- Your unmarried partner if you do not have children together
- Your unmarried partner’s children
- Your parents who live with you
- Other relatives who live with you unless legal guardian (provide documentation)

- **What income is to be included**

1. Everyone in the household's income is counted
2. All earned income (paystubs, W2's, current tax form, under the table income)
3. All other income – Child support/alimony, Interest/Rental Income, Self-Employed income, strike benefits, unemployment compensation, pension, retirement, railroad benefits, social security, disability, public assistance.
4. If there is no income in the household then a letter must be written stating who is supporting the patient.

Lorain County Health & Dentistry

Lorain County Health & Dentistry Sliding Fee Discount Program - 2019 Poverty Guidelines - effective 1/11/2019

Family Size-# of Persons in Family	Up to and Including 100% of Poverty Guidelines				101 - 120% of Poverty Guidelines				121 - 140% of Poverty Guidelines				141 - 160% of Poverty Guidelines			
	Income Minimum	Income Maximum	Nominal Charge Medical, Vision & Beh. Health*	Nominal Charge Dental	Income Minimum	Income Maximum	Discounted Fees Medical, Vision & Beh. Health	Discounted Fees Dental	Income Minimum	Income Maximum	Discounted Fees Medical, Vision & Beh. Health	Discounted Fees Dental	Income Minimum	Income Maximum	Discounted Fees Medical, Vision & Beh. Health	Discounted Fees Dental
1	$0	$12,490	$20	$35	$12,491	$14,988	$30	The greater of 10% of the fees or $36	$14,989	$17,486	$40	The greater of 20% of the fees or $37	$17,487	$19,984	$50	The greater of 40% of the fees or $38
2	$0	$16,910	$20	$35	$16,911	$20,292	$30		$20,293	$23,674	$40		$23,675	$27,056	$50	
3	$0	$21,330	$20	$35	$21,331	$25,596	$30		$25,597	$29,862	$40		$29,863	$34,128	$50	
4	$0	$25,750	$20	$35	$25,751	$30,900	$30		$30,901	$36,050	$40		$36,051	$41,200	$50	
5	$0	$30,170	$20	$35	$30,171	$36,204	$30		$36,205	$42,238	$40		$42,239	$48,272	$50	
6	$0	$34,590	$20	$35	$34,591	$41,508	$30		$41,509	$48,426	$40		$48,427	$55,344	$50	
7	$0	$39,010	$20	$35	$39,011	$46,812	$30		$46,813	$54,614	$40		$54,615	$62,416	$50	
8	$0	$43,430	$20	$35	$43,431	$52,116	$30		$52,117	$60,802	$40		$60,803	$69,488	$50	
9	$0	$47,850	$20	$35	$47,851	$57,420	$30		$57,421	$66,990	$40		$66,991	$76,560	$50	
10	$0	$52,270	$20	$35	$52,271	$62,724	$30		$62,725	$73,178	$40		$73,179	$83,632	$50	
11	$0	$56,690	$20	$35	$56,691	$68,028	$30		$68,029	$79,366	$40		$79,367	$90,704	$50	
12	$0	$61,110	$20	$35	$61,111	$73,332	$30		$73,333	$85,554	$40		$85,555	$97,776	$50	

Family Size-# of Persons in Family	161 - 180% of Poverty Guidelines				181 - 200% of Poverty Guidelines				More than 200% of Poverty Guidelines		
	Income Minimum	Income Maximum	Discounted Fees Medical, Vision & Beh. Health	Discounted Fees Dental	Income Minimum	Income Maximum	Discounted Fees Medical, Vision & Beh. Health	Discounted Fees Dental	Income	Medical, Vision & Beh. Health	Dental
1	$19,985	$22,482	$60	The greater of 60% of the fees or $39	$22,483	$24,980	$70	The greater of 80% of the fees or $40	$24,981 and above	No Discount	
2	$27,057	$30,438	$60		$30,439	$33,820	$70		$33,821 and above		
3	$34,129	$38,394	$60		$38,395	$42,660	$70		$42,661 and above		
4	$41,201	$46,350	$60		$46,351	$51,500	$70		$51,501 and above		
5	$48,273	$54,306	$60		$54,307	$60,340	$70		$60,341 and above		
6	$55,345	$62,262	$60		$62,263	$69,180	$70		$69,181 and above		
7	$62,417	$70,218	$60		$70,219	$78,020	$70		$78,021 and above		
8	$69,489	$78,174	$60		$78,175	$86,860	$70		$86,861 and above		
9	$76,561	$86,130	$60		$86,131	$95,700	$70		$95,701 and above		
10	$83,633	$94,086	$60		$94,087	$104,540	$70		$104,541 and above		
11	$90,705	$102,042	$60		$102,043	$113,380	$70		$113,381 and above		
12	$97,777	$109,998	$60		$109,999	$122,220	$70		$122,221 and above		

*** Patients eligible for the nominal charge who are receiving Behavioral Health Services, will be charged the $20 nominal charge for their first visit in their Beh. Health treatment plan and $5 per visit for subsequent visits in their Beh. Health treatment plan.**

For families with more than 12 persons, add **$4,420** for each additional person.

No patient will be denied services due to inability to pay

In the event you are unable to pay your account balance, please ask to speak with a Billing Associate about your options

Please ask to speak with a Financial and Enrollment Assistant for more information on the Lorain County Health & Dentistry Sliding Fee Discount Program

Lorain County Health & Dentistry

Lorain County Health & Dentistry Programa de Descuento con Cobros en Escala - 2019 Nivel de Pobreza – efectivo 01/11/2019

Tamaño familiar # de personas en la familia	100% nivel de pobreza				101 - 120% nivel de pobreza				121 - 140% nivel de pobreza				141 - 160% nivel de pobreza			
	Ingreso Minimo	Ingreso Maximo	Cargos Nominal Medicos/Vision/Servicios de Comportamiento	Cargos Nominal Dental	Ingreso Minimo	Ingreso Maximo	Tarifas con descuento Medicos/Vision/Servicios de Comportamiento	Tarifas con descuento Dental	Ingreso Minimo	Ingreso Maximo	Tarifas con descuento Medicos/Vision/Servicios de Comportamiento	Tarifas con descuento Dental	Ingreso Minimo	Ingreso Maximo	Tarifas con descuento Medicos/Vision/Servicios de Comportamiento	Tarifas con descuento Dental
1	$0	$12,490	$20	$35	$12,491	$14,988	$30	Mayor de 10% del cargo o $36	$14,989	$17,486	$40	Mayor de 20% del cargo o $37	$17,487	$19,984	$50	Mayor de 40% del cargo o $38
2	$0	$16,910	$20	$35	$16,911	$20,292	$30		$20,293	$23,674	$40		$23,675	$27,056	$50	
3	$0	$21,330	$20	$35	$21,331	$25,596	$30		$25,597	$29,862	$40		$29,863	$34,128	$50	
4	$0	$25,750	$20	$35	$25,751	$30,900	$30		$30,901	$36,050	$40		$36,051	$41,200	$50	
5	$0	$30,170	$20	$35	$30,171	$36,204	$30		$36,205	$42,238	$40		$42,239	$48,272	$50	
6	$0	$34,590	$20	$35	$34,591	$41,508	$30		$41,509	$48,426	$40		$48,427	$55,344	$50	
7	$0	$39,010	$20	$35	$39,011	$46,812	$30		$46,813	$54,614	$40		$54,615	$62,416	$50	
8	$0	$43,430	$20	$35	$43,431	$52,116	$30		$52,117	$60,802	$40		$60,803	$69,488	$50	
9	$0	$47,850	$20	$35	$47,851	$57,420	$30		$57,421	$66,990	$40		$66,991	$76,560	$50	
10	$0	$52,270	$20	$35	$52,271	$62,724	$30		$62,725	$73,178	$40		$73,179	$83,632	$50	
11	$0	$56,690	$20	$35	$56,691	$68,028	$30		$68,029	$79,366	$40		$79,367	$90,704	$50	
12	$0	$61,110	$20	$35	$61,111	$73,332	$30		$73,333	$85,554	$40		$85,555	$97,776	$50	

Tamaño familiar # de personas en la familia	161 - 180% nivel de pobreza				181 - 200% nivel de pobreza				Mas de 200% nivel de pobreza		
	Ingreso Minimo	Ingreso Maximo	Tarifas con descuento Medicos/Vision/Servicios de Comportamiento	Tarifas con descuento Dental	Ingreso Minimo	Ingreso Maximo	Tarifas con descuento Medicos/Vision/Servicios de Comportamiento	Tarifas con descuento Dental	Ingreso	Cargos MEDICOS** Descuento Medicos/Vision/Servicios de Comportamiento	Descuento Dental
1	$19,985	$22,482	$60	Mayor de 60% del cargo o $39	$22,483	$24,980	$70	Mayor de 80% del cargo o $40	$24,981 y mas arriba	No descuento	
2	$27,057	$30,438	$60		$30,439	$33,820	$70		$33,821 y mas arriba		
3	$34,129	$38,394	$60		$38,395	$42,660	$70		$42,661 y mas arriba		
4	$41,201	$46,350	$60		$46,351	$51,500	$70		$51,501 y mas arriba		
5	$48,273	$54,306	$60		$54,307	$60,340	$70		$60,341 y mas arriba		
6	$55,345	$62,262	$60		$62,263	$69,180	$70		$69,181 y mas arriba		
7	$62,417	$70,218	$60		$70,219	$78,020	$70		$78,021 y mas arriba		
8	$69,489	$78,174	$60		$78,175	$86,860	$70		$86,861 y mas arriba		
9	$76,561	$86,130	$60		$86,131	$95,700	$70		$95,701 y mas arriba		
10	$83,633	$94,086	$60		$94,087	$104,540	$70		$104,541 y mas arriba		
11	$90,705	$102,042	$60		$102,043	$113,380	$70		$113,381 y mas arriba		
12	$97,777	$109,998	$60		$109,999	$122,220	$70		$122,221 y mas arriba		

Para familias de mas de 12 personas sumar $4,420 por cada persona adicional.

*** Los Pacientes que son elegibles para el cobro nominal por servicios de comportamiento, se le cobrará el costo nominal de $20 por su primera visita en su tratamiento, y $5 por visitas posteriores en su tratamiento por los servicios de comportamiento.**

A ningun paciente se le negará el servicio debido a la incapacidad de pago

Si por algun motivo no puede pagar el saldo de su cuenta, pida por favor hablar con un Asociado bilingue sobre sus opciones

Pida por favor hablar con un Representate Financiero para mayor informacion sobre el programa de descuento de Lorain County Health & Dentistry

Lorain County
Health & Dentistry

Sliding Fee Scale Application

The sliding fee scale is a method for providing reduced charges to patients who qualify. This application is good for 12 months from the date signed. You must reapply every 12 months. Circumstances that may affect your discount include divorce, death of spouse, leave of absence from work, dependent turning 18 who is not a full-time student. Additional verification may be required.

List the names of all persons indicated below, starting with yourself:

Do Include:

- Yourself * Your Spouse
- Your children under 19 who live with you and their children who also live with you (if employed please provide their proof of income)
- Your unmarried partner IF you have a common child together that resides in the household
- Anyone else under 19 that lives with you if you are their legal guardian and have proper documentation
- Your children 19-26 who live with you and are full time students (living at the school campus is considered "living with you") (provide documentation of school enrollment)

Do NOT Include

- Your unmarried partner if you do not have children together
- Your unmarried partner's children * Your parents who live with you
- Other relatives who live with you unless legal guardian (provide documentation)

SFS Eligible	Full Name	Social Security # *(optional)*	Date of Birth	Relationship	Employer
Y N					
Y N					
Y N					
Y N					
Y N					
Y N					

Income includes *all income* for the *entire household* listed above. Please check appropriate box(es) of verification and attach a copy of the item to be verified.

- ❑ Federal Income Tax Return
- ❑ Employee W2s
- ❑ Child Support/Alimony
- ❑ Interest, Rental Income
- ❑ Other (self-employment income)
- ❑ Pay Stubs ❑ Weekly ❑ Bi-weekly
- ❑ Strike Benefits / Unemployment Comp
- ❑ Pension/Retirement/Railroad Benefits
- ❑ Social Security / Disability / Public Assistance
- ❑ I did not work or have any income

I have completed this application for discounted care and confirm that all information (including any self-attestations) provided is truthful to the best of my knowledge. I understand that I may be eligible, based on the proof I provided, for discounted care. I also understand that if I am eligible for a discount, I will be expected to pay the associated fee at the time of each office visit.

_____ _____ _____

Applicant Signature Phone Number Date

Providing false information on this form may affect your ability to get health care at Lorain County Health & Dentistry

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For Accounting Use Only:

Yearly Gross Income _____

Number of Eligible Household Members? _____

Pending Medicaid? _____

Expires _____

Medical/Vision/ Behavioral Health Nominal Charge/ Discounted Fees

Nominal Charge $20

Level _____ _____

Dental Nominal Charge/ Discounted Fees

Nominal Charge $35

The greater of _____% of the fees or
$36 $37 $38 $39 $40 circle one

Financial Representative _____ Date _____

Lorain County
Health & Dentistry

The following services are available at a reduced rate for patients who qualify for the Sliding Fee Scale.

Medical Services	**Dental Services**	**Vision Services**	**Behavioral Health**
Office Visits	Office Visits	Office Visits	Office Visits
Procedures	Procedures (except	Procedures	
Immunizations	Root Canals)		
Injections			

Services Not Covered Under the Sliding Fee Scale

Hospital services

Lab tests

Root Canals

Eye Glasses and related products

LARC Insertion – Patient will pay for the cost of product plus the office visit fee as determined by the completion of an SFS application. LARC removal will be done within an office visit and is subject to the applicable fees the patient is eligible for at the time of removal.

Patients are encouraged to submit a revised Sliding Fee Scale Application if one of the following conditions occurs:

Circumstances	**Verification Required**
Divorce	Letter from attorney stating a divorce is in process.
Death of Spouse	Obituary from newspaper or death certificate.
Loss of job	Waiting period 90 days with statement from Unemployment or employer.
Leave of Absence from Work	Waiting period 90 days with a statement form employer.
19 Year Old (Not Full-Time Student)	1 month of payroll check stubs or a statement from employer listing gross wages.

Lorain County Health & Dentistry

Hardship Appeal for Reduced/Waived fees

Instructions: Please complete the request for a hardship appeal for reduced/waived fees, which could result in reduced/waived fees. Supporting documentation is required. You will receive notification by letter at the address provided below.

Patient Information

Name: _____

Address: _____

Date of Birth: _____

Phone Number: _____

Please select the type of hardship assistance you are requesting from Lorain County Health & Dentistry:

- ☐ 1x visit at reduced/waived fees. Please indicate amount able to pay $_____.
- ☐ Past due balance forgiveness
- ☐ Other (please describe)_____

_____

_____

Please select which of the following hardships you are experiencing and <u>provide supporting documentation:</u>

- ☐ Terminal Illness (will be denoted in patient's chart)
- ☐ Unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member
- ☐ File for bankruptcy in past 3 months
- ☐ Other reasons that indicate the patient would be unable to pay medical bills and still be able to pay for other basic necessary expenses and/or expenses for medical necessity
- ☐ Catastrophic situation – death or disability of a family member, flood/fire/other of home, other natural disasters

Additional comments (not required) :

_____

_____

_____

Documentation received by: _____Date_____

Signature: _____ Date:_____

Approved by: _____ Date: _____