Primary Care Health Services, Inc.
Sliding Fee Scale Application

Site name _____

Account # _____

Date applied _____

I. Tell Us About Yourself

Your name _____
Address, including city and zip code _____
Telephone number _____
Your birthday _____
Your Social Security Number _____

II. Tell Us About Your Family: "family" will be defined as both traditional and non-traditional, a group of individuals; related by birth, marriage, or adoption and residing together or who are intimately related, living under the same roof, supporting and maintaining each other emotionally, economically, socially.

Please list the members of your household including yourself:

Full name	date of birth	social security number

III. Tell Us About Your Household Income

How does your family take care of their expenses?

- ✓ **All income** that your family receives before tax deductions **must be listed** for the past 30 days.
- ✓ Please **attach proof of that income** to this application.

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Type of Income	Amount	What did you attach to verify this?
Employment/Job/W-2	$	
Net receipts self-employment	$	
Social security	$	
Railroad Retirement	$	
Unemployment compensation	$	
Worker's Compensation	$	
Strike benefits from union funds	$	
Veteran's benefits	$	
Public Assistance	$	
Cash Assistance Program	$	
Food Stamps	$	
Supplemental Security Income	$	
Training Stipend	$	
Alimony	$	
Child Support	$	
Military Family Allotment	$	
Family and/or friend(s)	$	
Pension private	$	
Pension government	$	
Annuity payments	$	
Regular insurance payments	$	
Income from dividends/interest	$	
Rents, royalties, estates, trusts	$	

My family earns $ _____ before taxes every

Circle one: YEAR MONTH WEEK

IV. Truth of Statement

The facts set forth in this application are true and complete to the best of my knowledge. I understand and accept the fact that a false or incomplete statement on this application will be cause for rejecting my application, at which point I will be responsible for 100% of any medical or dental expenses accrued at Primary Care Health Services, Inc.

_____ _____

Witnessed by & date **Your Signature & date**

V. Sliding Fee Disclosure

The income guidelines change annually. Re-evaluation for sliding fee is required if there is a change in your income status during the year. You are required to have your application updated annually, even if your income has remained the same or your fee will revert back to 100%.

- ✓ *The **nominal range** on the sliding fee **does not apply to Dental Services**.*
- ✓ *The **fees for driver physicals and pre-marital exams are set at $27.00**.*
- ✓ *You may also use your Master Charge or VISA if you wish.*
- ✓ ***Patients are required to pay at the time of each visit**.*

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YOUR NEXT SCHEDULED REVIEW DATE WILL BE: April 15th unless there is a change in your income status.

VI. Summary: (To be completed along with PCHS' Staff)

Mr./Mrs./Ms. _____ total yearly, monthly, or weekly income is $ _____, the family size is _____, and therefore is responsible for _____% medical, _____% dental & _____% behavioral health services covered under the sliding fee scale at all PCHS sites.

Adjustments to this account may occur on covered services received within the proceeding thirty (30) day period.

Effective date of adjustment **_____** **Your *initials*_____**

I understand the policy regarding services provided under the sliding fee scale, which has been discussed with me. I agree to pay for covered services at the established rates. All other services will be paid at the prevailing rate.

_____ _____

Witnessed by & date **Your Signature & date**

Some **Health Resources**

- ❒ Children under the age of 18 years old; the **Children's Health Insurance Program** (CHIP), may be helpful. Call (412) 456-1877 for an application & support.
- ❒ **Partnership for Prescription Assistance** call to see if you qualify for free or reduced cost prescription program(s) 1 888-477-2669
- ❒ Adults over the age of 65 years of age; the **PACE** program may be able to help with your prescription costs. Call 1-800-225-7223 for an application to be mailed to you.
- ❒ **Behavioral Health Prescription Program**/Allegheny County, Department of Human Services 412 350-3426 or 412 350-5753, provides psychiatric prescription medication at no cost to eligible individuals. Eligibility is based on family income & the number of people in the household and expenses.
- ❒ **Ryan White AIDS Drug Assistance Program (ADAP)** provides HIV drugs to people with HIV/AIDS who don't have health insurance or have private health insurance that doesn't pay for the drugs. Call **AIDS Hotline;** in Pennsylvania: (800) 662-6080, Health Department: (717) 783-0572
- ❒ DPW/Medical Assistance Program, call (412) 697-4697 to schedule an appointment or contact your local county assistance office.