Embracing Excellence in Healthcare

Determining Eligibility

Primary Health Network, Inc. is a Federally Qualified Health Center. We are able to offer a discount on some services based on a household’s income and size. Sliding fee calculations are determined by using Federal Income Tax forms, W-2’s, or last two consecutive pay stubs. PHN then uses the table on the inside of this brochure to determine your eligibility.

Your household discount will be assessed on an annual basis.

PLEASE NOTE: Patient may be responsible for the payment of some procedures, labs and medications.

If you have any questions, please contact PHN’s Patient Experience/We Care Customer Service Department at 1-866-276-7018 or email wecare@primary-health.net

Return completed application to:
P.O. Box 716
Sharon, PA 16146

TO BE COMPLETED BY PHN STAFF

Annual Gross Income $ ______________

Patient is eligible for sliding fee discount in category _______________________

☐ Proof of income verified.
☐ Patient refused to complete.
☐ Patient does not qualify for sliding fee.

Verified By __________________________  Date __________________________

If you wish to qualify for the sliding fee, you MUST show proof of income for all family members/individuals living in your household or individuals for whom you are financially responsible. If you do not have any source of income, please speak with a staff member. Applicants should provide a copy of either:

- Two consecutive pay stubs for each employed adult age 18 and over living in the household, or living outside the household but for whom the household is financially responsible
- Previous year’s tax return or W-2 for each adult living in the household or for whom the household is financially responsible

(Income will come from Gross Income line on respective tax return)

Name: ________________________________

Date of Birth: __________________________

Family Size: ____________________________

(Number of family members living in your household.)

List name(s) and date(s) of birth of family members/individuals living in your household or individuals for whom you are financially responsible.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Address: ________________________________

Phone: _________________________________

Do you have insurance? YES ☐ NO ☐

If yes, please provide:
Medical plan name: __________________________

Dental plan name: __________________________

DISCLAIMER:
I hereby certify that the above information is, to the best of my knowledge, true and correct. I further agree to notify The Primary Health Network of any changes in this information within ten (10) days of such change.

I understand that I must re-qualify annually to maintain my eligibility.

I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government. Sliding fee payment is due and payable at the time of service. To maintain discount, fees must be paid promptly. If you are unable to make payment at time of service, please contact PHN’s Patient Experience/We Care Customer Service at 1-866-276-7018 to make other payment arrangements.
## Exclusions - Category 0

**MEDICAL**
- Lab costs
- Medical devices
- Injectable costs

**DENTAL**
- Dentures
- Crowns
- Bridge surgery
- Dental lab costs

## Exclusions - Category 1-3

**MEDICAL**
- Lab costs
- Some in-office surgeries/procedures
- Injectables
- No offsite services are eligible, such as hospital, hospital services, and nursing homes

**DENTAL**
- The following will be billed at 75% of actual charges:
  - Dentures
  - Crowns
  - Bridge work
  - Oral surgery
  - Dental lab fees

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### Sliding Fee Discount
(Based on Federal Register 2019 - Poverty Income Guidelines)

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Measure</th>
<th>Category 0</th>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of Federal Poverty Income Guidelines</td>
<td>Patient Fee: $0</td>
<td>Patient Fee: $15</td>
<td>Patient Fee: $25</td>
<td>Patient Fee: $35</td>
<td>Self-Pay</td>
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<tr>
<td>1</td>
<td>Annual</td>
<td>$0 – $12,490</td>
<td>$12,491 – $18,734</td>
<td>$18,735 – $21,856</td>
<td>$21,857 – $24,980</td>
<td>$24,981 +</td>
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<tr>
<td></td>
<td>Monthly</td>
<td>$0 – $1,041</td>
<td>$1,042 – $1,561</td>
<td>$1,562 – $1,822</td>
<td>$1,823 – $2,082</td>
<td>$2,083 +</td>
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<tr>
<td>2</td>
<td>Annual</td>
<td>$0 – $16,910</td>
<td>$16,911 – $25,363</td>
<td>$25,364 – $29,591</td>
<td>$29,592 – $33,820</td>
<td>$33,821 +</td>
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<tr>
<td></td>
<td>Monthly</td>
<td>$0 – $1,409</td>
<td>$1,410 – $2,113</td>
<td>$2,114 – $2,466</td>
<td>$2,467 – $2,818</td>
<td>$2,819 +</td>
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<tr>
<td>3</td>
<td>Annual</td>
<td>$0 – $21,330</td>
<td>$21,331 – $31,993</td>
<td>$31,994 – $37,325</td>
<td>$37,326 – $42,660</td>
<td>$42,661 +</td>
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<tr>
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<td>Monthly</td>
<td>$0 – $1,778</td>
<td>$1,779 – $2,667</td>
<td>$2,668 – $3,111</td>
<td>$3,112 – $3,556</td>
<td>$3,557 +</td>
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<tr>
<td>4</td>
<td>Annual</td>
<td>$0 – $25,750</td>
<td>$25,751 – $38,622</td>
<td>$38,623 – $45,060</td>
<td>$45,061 – $51,500</td>
<td>$51,501 +</td>
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<tr>
<td>5</td>
<td>Annual</td>
<td>$0 – $30,170</td>
<td>$30,171 – $45,252</td>
<td>$45,253 – $52,794</td>
<td>$52,795 – $60,340</td>
<td>$60,341 +</td>
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<tr>
<td></td>
<td>Monthly</td>
<td>$0 – $2,514</td>
<td>$2,515 – $3,771</td>
<td>$3,772 – $4,399</td>
<td>$4,400 – $5,028</td>
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<tr>
<td>6</td>
<td>Annual</td>
<td>$0 – $34,590</td>
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<td>$51,883 – $60,529</td>
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<td>$69,181 +</td>
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<tr>
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<td>Monthly</td>
<td>$0 – $2,883</td>
<td>$2,884 – $4,324</td>
<td>$4,325 – $5,045</td>
<td>$5,046 – $5,766</td>
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<td>7</td>
<td>Annual</td>
<td>$0 – $39,010</td>
<td>$39,011 – $58,511</td>
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<td>$68,265 – $78,020</td>
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<tr>
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<td>Monthly</td>
<td>$0 – $3,251</td>
<td>$3,252 – $4,876</td>
<td>$4,877 – $5,689</td>
<td>$5,690 – $6,502</td>
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<tr>
<td>8</td>
<td>Annual</td>
<td>$0 – $43,430</td>
<td>$43,431 – $65,141</td>
<td>$65,142 – $75,998</td>
<td>$75,999 – $86,860</td>
<td>$86,861 +</td>
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<tr>
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<td>Monthly</td>
<td>$0 – $3,619</td>
<td>$3,620 – $5,428</td>
<td>$5,429 – $6,333</td>
<td>$6,334 – $7,238</td>
<td>$7,239 +</td>
</tr>
</tbody>
</table>

*each additional family member + $4,420 A / $368 M* each additional family member + $4,420 A / $368 M + $6,630 A / $553 M + $7,735 A / $644 M + $8,840 A / $737 M

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For more information, please contact us at 1-866-276-7018.