Sliding Fee
Discount Application

Primary Health Network 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 an applicant's total annual income provided by the complete Federal Income Tax return(s), W-2(s) or 1099(s), most recent pay stubs spanning four weeks, Social Security or Pension Income, Public Assistance award letters, and unemployment compensation. PHN uses the Federal Poverty Guidelines (table displayed on reverse side) to determine your eligibility.

Your household discount will be assessed once per year. You must reapply for the Sliding Fee discount and provide updated income documentation at this time.

PLEASE NOTE: You may be responsible for the payment of some procedures, labs, and medications. If you have any questions, please contact the PHN Billing Department at 1-888-274-2043.

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 the following documents, if applicable:

- Previous year's tax return, W-2's or 1099's
- Most recent pay stubs spanning four weeks
- Social Security or Pension Income
- Public assistance award letters for each adult age 18 and over living in the household.
- Unemployment compensation

This will also include those members living outside the household but for whom the household is financially responsible (Income will come from the Total Income line on respective tax return).

Return completed application(s) and income documentation within 30 days to any PHN location or mail directly to:
Primary Health Network, Attn: Billing Department, P.O. Box 716, Sharon, PA 16146

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 the PHN Billing Department at 1-888-274-2043 to make other payment arrangements.

_____ _____

Signature **Date**

FOR INTERNAL USE ONLY

Annual Gross Income _____

Patient is eligible for sliding fee discount category _____

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

_____

Verified by Date

Sliding Fee Scale

Based on Federal Register 2021 Poverty Guidelines

Family Size	Income Measure	Category 0	Category 1	Category 2	Category 3	Category 4
% of Federal Poverty Income Level		Up to 100%	100.01%-149.99%	150.00%-174.99%	175.00%-199.99%	200.00%+
		Patient Fee: $0.00	Patient Fee: $10.00	Patient Fee: $20.00	Patient Fee: $30.00	Patient Fee: 100%
1	Annual Monthly	$0 – $12,880 $0 – $1,073	$12,881 – $19,319 $1,074 – $1,609	$19,320 – $22,539 $1,610 – $1,878	$22,540 – $25,760 $1,879 – $2,146	$25,761 + $2,147 +
2	Annual Monthly	$0 – $17,420 $0 – $1,452	$17,421 – $26,128 $1,453 – $2,178	$26,129 – $30,483 $2,179 – $2,541	$30,484 – $34,840 $2,542 – $2,904	$34,841 + $2,905 +
3	Annual Monthly	$0 – $21,960 $0 – $1,830	$21,961 – $32,938 $1,831 – $2,745	$32,939 – $38,428 $2,746 – $3,202	$38,429 – $43,920 $3,203 – $3,660	$43,921 + $3,661 +
4	Annual Monthly	$0 – $26,500 $0 – $2,208	$26,501 – $39,747 $2,209 – $3,312	$39,748 – $46,372 $3,313 – $3,864	$46,373 – $53,000 $3,865 – $4,416	$53,001 + $4,417 +
5	Annual Monthly	$0 – $31,040 $0 – $2,587	$31,041 – $46,557 $2,588 – $3,880	$46,558 – $54,317 $3,881 – $4,527	$54,318 – $62,080 $4,528 – $5,174	$62,081 + $5,175 +
6	Annual Monthly	$0 – $35,580 $0 – $2,965	$35,581 – $53,366 $2,966 – $4,447	$53,367 – $62,261 $4,448 – $5,188	$62,262 – $71,160 $5,189 – $5,930	$71,161 + $5,931 +
7	Annual Monthly	$0 – $40,120 $0 – $3,343	$40,121 – $60,176 $3,344 – $5,014	$60,177 – $70,206 $5,015 – $5,850	$70,207 – $80,240 $5,851 – $6,686	$80,241 + $6,687 +
8	Annual Monthly	$0 – $44,660 $0 – $3,722	$44,661 – $66,986 $3,723 – $5,583	$66,987 – $78,151 $5,584 – $6,513	$78,152 – $89,320 $6,514 – $7,444	$89,321 + $7,445 +
Each additional family member		+ $4,540 A + $373 M	+ $4,540 A + $373 M	+ $6,810 A + $560 M	+ $7,945 A + $653 M	+ $9,080 A + $747 M

EXCLUSIONS - CATEGORY 0

MEDICAL

The following will be billed at 100% of PHN's actual costs:

- Injectables

DENTAL

The following will be billed at 100% of PHN's actual costs:

- Dental lab cost associated with dentures, crowns, or bridge work

EXCLUSIONS - CATEGORY 1-3

MEDICAL

The following will be billed at 100% of the actual charge based on PHN's fee schedule:

- Some in-office surgeries/procedures
- Certain injectables
- Off-site services, such as hospital, hospital services, and nursing homes

DENTAL

The following will be billed at 75% of the actual charge based on PHN's fee schedule:

- Dentures
- Crowns
- Bridge Work
- Oral Surgery