"Healing with Heart"
Elica Health Centers

SLIDING FEE DISCOUNT PROGRAM APPLICATION

At Elica Health Centers, we offer a Sliding Fee Discount to make our services more affordable to all patients.

- If you already receive Social Security Disability income (SSDI), Temporary Assistance for Needy Families (TANF), or any other public assistance programs, you may be eligible for the Sliding Fee Discount Program.

The following criteria apply to the sliding fee scale, which is based on the current Federal Poverty Guidelines (FPG):

- You must complete the application on the reverse and re-apply in six months, or when your household or income changes, whichever comes first.
- You are required to provide proof of income as instructed on the application. Self-declaration of income will qualify the patient for one visit only, but can be changed within ten days of visit.
    - If you have no income or are unable to provide proof of income, please fill out the self-declaration form. You may still be eligible for the Sliding Fee Discount Program.
- Approval is based on household size and gross income.
- Participants are expected to pay their share of the discounted fee at the time of service.
    - Patients can also arrange to make regular payments until the balance is paid.
    - A charge for today's services will reflect the sliding fee scale below. If you qualify on the sliding fee scale, this will be your nominal fee and no other charges will be billed.
    - Sources of acceptable payments are:
        1. Cash
        2. Credit Cards (VISA, MasterCard). Checks are not acceptable.

If eligible to enroll in Medi-Cal, please ask us for more information. We would be happy to provide resources such as:

- Evaluation if you are eligible for full scope Medi-Cal
- Assistance with filing the MC-13 PRUCOL form
  (if you only have Emergency Medi-Cal and want to request full coverage)
- Provide Department of Human Assistance location contact information or help schedule a visit with Sacramento Covered
- Provide information and estimate income limits for Medi-Cal or other programs.
- Provide information and help find information about programs (e.g., for oncology, diabetes) if the patient is not eligible for any insurance.

If you have questions, please contact a staff member from one of EHC locations, or call at (916) 454-2345.

SLIDING FEE DISCOUNT SCHEDULE

Elica Health Centers: Sliding Fee Schedule			Sliding Fee Scale: (Based on Federal Register Poverty Income Guidelines)			
Discount Categories	**Category A**	**Category B**	**Category C**	**Category D**	**Category E**	**Full Pricing**
% of Federal Poverty Income Levels	**At or below 100% (FPG)**	**>100 - 125%**	**>125 - 150%**	**>150 - 175%**	**>175 - 200%**	**> 200 %**
Medical / Behavioral Health	**Nominal Fee**	**Discounted Fees**				**Full Pricing**
All Inclusive Visit (1)	**$25**	**$35**	**$45**	**$55**	**$65**	
Internal Diagnostic labs (2)	**$5**	**$6**	**$7**	**$8**	**$9**	
Lab referral (3)	**$30**	**$31**	**$32**	**$33**	**$34**	
Electives & Other Special Items (see schedule below) (4)	**see #4 below**					
Dental Program	**Nominal Fee**	**Discounted Fees**				**Full Pricing**
All Inclusive Visit: diagnostic, preventive, periodontal, & emergencies (1)	**$25**	**$35**	**$45**	**$55**	**$65**	
Major / Bundled Professional fees: bridges, crowns, dentures, & root canals (5)	**$25**	**$35**	**$45**	**$55**	**$65**	
Major / Bundled: lab/equipment (5)	**see schedule below**					

1. All-inclusive visits include professional services and all routine supplies, injectables, and vaccines.
2. Internal labs are medical diagnostic labs performed on site.
3. Lab referrals are medical diagnostic labs performed off site by Quest Diagnostics or other reference labs.
4. Electives and other special items with special pricing (based on actual cost):

   Depo Provera $45 — Other IUDs $600

   Liletta IUD $105 — Night guards $95
5. Major/Bundled Dental includes services such as treatment planning, special labs and/or equipment. These services may be bundled into two or more appointments. An Elica Treatment Coordinator will explain the process and provide financial counseling services. The patient is expected to pay 50% before services can begin and the remaining balance will be set up on a payment plan. See schedule below.

Patient pays discounted professional fee for each visit plus a one-time fee according to this schedule:

Major Service	**Category A**	**Category B**	**Category C**	**Category D**	**Category E**	**Full Pricing**
Root Canal (per canal)	**$175**	**$200**	**$225**	**$250**	**$275**	
Crown/Bridge (per unit)	**$150**	**$170**	**$190**	**$210**	**$230**	
Full Denture (per arch)	**$400**	**$450**	**$500**	**$550**	**$600**	
Partial Denture (per arch)	**$450**	**$500**	**$550**	**$600**	**$650**	

APPLICATION FOR SLIDING FEE PROGRAM ELIGIBILITY

1. Have you applied for Medi-Cal, and been DENIED benefits within the last 60 days? ❒ Yes ❒ No
2. Total Number of dependents living in your household (include yourself/spouse, children, and any taxable dependent relatives living with you: _____

You must provide proof of income for every adult household member. Examples are: a copy of the most recent tax return, your two most current pay stubs or W2's, child support check stubs, social security statements, disability / workers' compensation check stubs, letter of support, etc. Please ask for help in determining acceptable proof of income. You must submit documentation within 10 days of your application. Failure to do so will result in the return of your application and delay in approval.

Patient Name: _____ Birth Date: _____

					For Internal Use Only	
Name	Relationship	Date of Birth	Income Amount	Income Type	Date Received	Type of Documentation
	self			❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		

I hereby request Elica Health Centers to determine my eligibility for the sliding fee program, based on the information I have submitted. I understand that the information, which I submit concerning my family income and size, is subject to verification. I also understand that if the information, which I submit, is determined to be false, I will be liable for all services at full charge. In signing this application, I affirm that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Elica Health Centers of all changes to my insurance information and should I fail to do so, payment in full of all services rendered will be my responsibility.

Signature: _____ Date:_____

VERIFICATION AND DETERMINATION (Office Use Only)

1. Monthly income verification attached: ❒ Yes ❒ No (Initial Self-Declaration)
2. Slide Effective Date: _____
3. Qualified fee reduction: ❒ ≤100% ❒ 101-125% ❒ 126-150% ❒ 151-175% ❒ 176-200% ❒ ≥200%
4. Length of reduction: ❒ 1st Visit ❒ 6 months

Verification and determination by: _____ Date: _____

"Healing with Heart" Elica Health Centers

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name	**MRN:**	**Today's Date** (month/day/year)
Date of Birth (month/day/year)		

SELF-DECLARATION FORM

I, _____, do hereby attest that:

❒ **Option 1: Cash Income**

I am unable to provide proof of income due to the nature of my work. I attest that

I receive _____ per (hour / month / annual / other: _____).
(dollars) (please choose one of the above options)

❒ **Option 2: Letter of Support**

I receive _____ per month from _____ (_____)
(dollars) (supporter's name) (relationship)

❒ **Option 3: No Income**

Neither I nor any other member of my household has any source of income.

❒ **Option 4: Not Applicable**

I am able to provide proof of income, therefore the above options do not apply to me.

By signing below, I agree that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Elica Health Centers of all changes to my income and support.

_____	_____
Patient / Representative Signature	Date
_____	_____
Print Name	Relationship to Patient