HORIZON Health Care, Inc.

SLIDING FEE APPLICATION

Thank you for your interest in Horizon Health Care, Inc.'s Sliding Fee Program. This program is intended to help defer some of the out-of-pocket medical and dental expenses for individuals with or without insurance. In order to qualify we require that you provide documentation of your household income. If this is your first visit to one of our clinics we will allow you to self-declare your income and provide documentation following the visit to avoid delaying care but you must provide documentation if you wish to qualify for a reduction in fees for any subsequent visits.

If you wish to apply for a sliding fee discount please follow the directions below, fill out the attached application in its entirety and provide the requested documentation. You may qualify for fee reductions retroactively prior to the date your application is received if the proper documentation is provided. The amount of your fee reduction is determined by the Federal Poverty Guidelines with a minimum fee for office visits of $20 for medical and $35 for dental.

STEP 1) FILL OUT THE SLIDING FEE APPLICATION. Please remember to include all household members and sign your application.

STEP 2) PROVIDE PROOF OF YOUR INCOME. Please provide ***one*** of the following documents for ALL members of your household (related and unrelated) to show household income:

- Two most recent paystubs
- Current Tax Return
- Current W-2s from all employment
- Bank Statements showing all activity for the last three months
- Social Security or Unemployment Award Letter
- Amounts received in public assistance (rental assistance or food stamps, etc.) or a signed Release of Information

If you do not receive income from any source please provide one of the following:

- Letter from a government office explaining the benefits you do or do not qualify for (unemployment office or social security office, etc.).
- Denial letter for an application of benefits (must be dated within the last 3 months).
- Anyone claiming to have no income but lacks a documented explanation will be required to reapply and submit a completed sliding fee application each visit.

STEP 3) RETURN YOUR SLIDING FEE APPLICATION, along with the supporting documentation, to the front desk of any of our Horizon dental or medical clinics or you may mail it to our Horizon Health Care Billing Department: 602 1st St NE Suite 1, Wessington Springs, SD 57382.

STEP 4) PAY YOUR CO-PAY OR FEES FOR TODAY'S OFFICE VISIT.

The Billing Department will process your application and send you a letter in the mail explaining whether or not you qualify based on your application. If additional documentation is needed they will contact you by telephone or mail. Please allow up to 30 days for processing your application after it is received.

If it is determined that you do not qualify for our sliding fee program you will be responsible for any charges not covered by insurance. If it is determined that you do qualify for our sliding fee program a credit will be given if you have overpaid for your clinic visit and have no other outstanding bills or past bad debt to Horizon Health Care, Inc.

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This information is STRICTLY confidential and your name will never be disclosed in any reports.

Please complete this form, listing everyone in your household, and their annual income.

Applicant Name_____ DOB: _____/_____/_____
Address _____ City _____ State _____ Zip _____
Phone # _____ Cell Phone # _____ Are you employed? ☐ Yes ☐ No

If you do not have any income from the past month and are going to self-attest today, please mark the box and fill out household assessment below and the statement on the next page.

☐ I am self-attesting (continue on next page)
☐ I am applying for the sliding fee and proving income verification (complete the below form, listing everyone in your household, and their annual income with a signature)

Source includes earnings, unemployment compensation, worker's compensation, social security, supplemental security income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources

Name (First Name, Middle Name, Last Name)	Relation to #1	Date of Birth	Sex at Birth	Social Security Number	Total Monthly Income	Total Annual Income	Source (Job, SSDI, Public Assistance, etc.)
1							
2							
3							
4							
5							
6							
7							

I, the undersigned, have completed this application for Sliding Fee eligibility and confirm that this information is true and correct, to the best of my knowledge. I further understand that should my economic situation change, I am solely responsible to report that upon my next visit. All information I provided within this application, including my self-attestation statement is truthful, correct and is subject to confirmation by Horizon Health Care. Any false statement or perceived attempt to deceive may result in a denial for sliding fee benefits and the balance associated with it would be my responsibility.

Signed: _____ Date:_____/_____/_____

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WRITTEN STATEMENT – SELF-ATTESTATION WITH NO INCOME

The sliding fee program is offered to our patients who qualify through an application process. It is required that you provide proof of your income or living situation. However, if you are applying today having no employment or income, you need to fill out the section below explaining your current living situation and list a name for contact information of family, friends or acquaintances that can attest to your current situation. The contact listed may be subject to review by staff to verify the information provided.

STATEMENT: (PLEASE PROVIDE INFORMATION IN THE BOX BELOW ABOUT YOUR LIVING SITUATION AND EXPENSES)

CONTACTS: (YOU MUST PROVIDE A CONTACT WHO CAN CONFIRM YOUR CURRENT LIVING SITUATION)

Name: _____ Contact Phone #: _____

Address: _____

Relationship to Patient: _____

I, _____, attest that I currently have no income to report at this time of service for care at the Horizon Health Care clinic I am attending. I further understand that should my economic situation change, I am solely responsible to report that upon my next visit. All information I provided within this application, including my self-attestation statement is truthful, correct and is subject to confirmation by Horizon Health Care. Any false statement or perceived attempt to deceive may result in a denial for sliding fee benefits and the balance associated with it would be my responsibility.

Signature: _____

Date:_____/_____/_____