HORIZON Health Care, Inc.

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 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 requested at the time of visit.**

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 (at least one statement with income circled)
- Social Security or Unemployment Award Letter
- Letter of benefits from public assistance offices (SNAP Award Letters, TANF) showing **INCOME** used to determine qualifications-(*Benefits awarded are not counted, only income or lack thereof, stating qualified amount.*)

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 Healthcare Billing Department: 602 1st St NE Suite 1, Wessington Springs, SD 57382.

Step 4) Patient notification of Qualification, additional fees, etc.

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.

SLIDING FEE APPLICATION

<u>This information is STRICTLY CONFIDENTIAL, and your name will never be disclosed in any reports</u>. 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 back of this page.

☐ I am self-attesting (continue on back side of this application) ***<u>*Application is good for today's visit only*</u>***
☐ 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) ***<u>*Application will expire on April 30th of the following year*</u>***

Source includes earnings, unemployment compensation, worker's compensation, social security, supplemental security income, veterans' payments, survivor benefits, rents, income from estates, trusts, alimony, 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 (M, F)	Social Security Number	Total Monthly Income	Total Annual Income	Source (Job, SSDI, Unemployment Benefits)
1	Self						
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 the change 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:_____

SLIDING FEE APPLICATION

Self-Attestation with No Income

Horizon Health Care, Inc allows for patients to self-attest if they are currently unemployed and/or do not receive income at the time of service. If you are self-attesting today, your application is only good for **today's visit**. It will expire after today's visit and you will need to fill out the application again if you are still unemployed and/or do not receive income for any visit(s) hereafter. Please fill out the information below to support this Self-Attestation. **Failure to answer these questions may result in your application being denied.**

1.) How long have you been unemployed and/or been without any income?

_____

2.) What is your current status?

___ Looking for work ___ Applying for disability ___ Temporarily laid off
___ Full-Time Student ___ Other

If Other, please explain:

_____
_____
_____

3.) Do you receive benefits or assistance with living expenses for any of the following? (check all that apply)

___ **Rent/Housing** ___ **Energy Assistance** ___ **Food Stamps** ___ **Unemployment**
___ Friends/ Family ___ TANF ___ Churches ___ Non-Profit Organizations ___ Shelters
___ Child Support ___ Student Loans ___ Other

4.) If you do not receive assistance from any of the above, how are you paying for basic living expenses? (ex. Rent, utilities, food, clothing, etc.)

_____
_____
_____
_____

I, _____, attest that I currently have no income to report at this time of service for care at Horizon Health Care, Inc. 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 any patient balance will be my responsibility.

Signed: _____ Date:_____