ReGenesis Health Care

My Family. My Doctor. My Choice.

Sliding Fee Discount Program Informational

ReGenesis Health Care is funded in part by federal grant dollars, patient income, and donations. Because we are federally funded, we are able to offer comprehensive healthcare services to our community on a Sliding Fee Scale, making access to excellent health care possible for everyone. We do accept most major insurances as well as Medicaid and Medicare.

What is a Sliding Fee?

A Sliding Fee Scale Application determines the portion you pay for your healthcare, which is dependent upon your financial resources and ability to pay.

All medical patients on a Sliding Fee Scale must pay their copayment at the time of service delivery. All dental patients on a Sliding Fee Scale must pay the percentage of the costs of any dental services performed at the time services are rendered. If you are unable to pay your entire co-payment at the time of service, you will be required to complete a Payment Plan that outlines how you will satisfy your obligation.

For all medical and dental patients with a 30-day balance, you will be required to setup a Payment Plan that will allow you to avoid the collections process and remain in good standing with ReGenesis Health Care.

Please remember that without your continued support, we will be unable to provide these much-needed services for our community! We also offer online payment options via Healow, our patient services portal for your convenience, mail, or you can stop by any of our locations and make your payment.

_____ _____

Patient or Guardian Signature Date

_____ _____

Patient Services Representative Date

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Sliding Fee Discount Application

We will not honor this discount application without proof of income

☐ **Yes, I have reviewed and signed the ReGenesis Health Care Sliding Fee Discount Program Informational and would like to apply for this discount. I will provide proof of income for every working member of my household 18 years or older.**

Date: _____

Name: _____ **Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone Number: _____ **Social Security Number (optional):**

Members of Household: _____

Please list all members that live in your household:

Full Name _____ **DOB** _____ **Relationship to you** _____

Full Name _____ **DOB** _____ **Relationship to you** _____

Full Name _____ **DOB** _____ **Relationship to you** _____

Full Name _____ **DOB** _____ **Relationship to you** _____

Full Name _____ **DOB** _____ **Relationship to you** _____

Employment Information:

Employer: _____ **Pay Status:** ☐ **Weekly** ☐ **Biweekly** ☐ **Monthly**

Rate of Pay: _____ **How many hours a week do you work?** _____

Employer: _____ **Pay Status:** ☐ **Weekly** ☐ **Biweekly** ☐ **Monthly**

Rate of Pay: _____ **How many hours a week do you work?** _____

Gross Total Salary: $ _____

Other sources of income:

☐ **Tax Return** ☐ **A letter on employer's letterhead verifying wages; verified by** _____

☐ **Child Support** _____ ☐ **Pension/Retirement** _____ ☐ **Bank statements**

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☐ **Social Security**_____ ☐ **Disability**_____ ☐ **Unemployment**_____

☐ **SNAP benefits**_____ ☐ **Alimony**_____ ☐ **Workers Compensation**_____

☐ **Rental Property Income** _____ ☐**Other Income Sources**_____

- **I agree to give proof of my total household income to ReGenesis Health Center every twelve months for verification of qualification and/or if there is a change of status in my income source before the twelve months have expired.**
- **If at any time while I am a patient at ReGenesis Health Care I receive private health insurance including Medicaid or Medicare, I must present proof of insurance coverage to the Front Desk Staff at the time of service.**
- **I understand that if I do not provide proof of income at the time of service, I will be responsible for paying 100% of the total bill for all services rendered until proof has been provided.**

MEDICAL PATIENTS: I _____hereby certify that all information contained within this application is true and correct. I understand that falsification of any information may void discounts given. I hereby authorize ReGenesis Health Care to contact persons/employers named on this application for verification. Based on the information presented in this application I qualify for a sliding fee discount level _____, which means I will pay a nominal fee of _____before services are rendered.

DENTAL PATIENTS ONLY: Based on the information provided in this application I qualify for a sliding fee discount level _____, which means I will pay _____% up front before any dental services are rendered.

This application will expire in one year on _____and I understand I must re-apply at that time.

****If you have insurance, by completing this application you may also qualify for prescription copayment assistance at any ReGenesis Health Care pharmacy****

Applicant or Guardian Signature	**Date**	**Patient Services Representative Signature**	**Date**

Manager Signature	**Date**