Pediatric Associates

156 Island Creek Road
Pikeville, KY 41501

Phone 606-666-5142
Fax 606-666-4172

Sliding Fee Discount Program

As a National Health Service Corps site, we promise to serve all patients. We do not deny services based on a person's race, color, sex, age, national origin, disability, religion, gender identity, sexual orientation, or inability to pay. Our clinic accepts insurance, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP).

We offer discounted fees for patients who qualify. Our staff is available to assist you in determining your eligibility for a variety of health benefits coverage options. These options may include a sliding fee scale discount, special grant-provided services, or public-funded health care coverage. Eligibility is based on gross household income and family size. To determine eligibility, you (the patient) must bring **ONE** of the following items along with a completed Sliding Fee Discount Program Application:

- current year's tax form (1040 form),
- 2 current pay stubs,
- 1 unemployment stub, or
- letter from employer on letterhead that states your salary or wages.

If you have none of the above items available, you must provide a letter of reference from any 501(c)(3) (non-profit) organization on their letterhead (for example, your church).

The patient/responsible party must complete the Sliding Fee Discount Program Application in its entirety. Persons signing the Sliding Fee Discount Program Application authorize our clinic to confirm income as disclosed on the application form. Providing false information on the application will result in discounts being revoked and the full amount of the account being restored and payable immediately.

If further information is needed for the application, our staff will contact the patient and will allow two weeks in which to provide this information to the clinic. After two weeks, the patient's application will be redated from the date the information is received. Any expenses incurred during this delay will be the responsibility of the patient. The discounted scale will not apply to these charges.

Thank you for choosing us as your medical provider.

HHS POVERTY GUIDELINES FOR 2020

PERSONS IN FAMILY HOUSEHOLD	POVERTY GUIDELINE
For families/household with more than 8 person, add $4,480 for each additional person.	
1	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120

The 2020 Poverty Guidelines are in effect as of January 17, 2020.

The **PERCENT OF DISCOUNT** is based upon **Family Size** and **Income** ONLY. SMC relies upon Census Bureau definitions of family and income:
Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.
Income includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.

Families or individuals earning at or below 100% of the Federal Poverty guidelines will incur only a nominal fee of $40.00 per office visit. Those between 100% and 200%, will be billed based upon the percentages as scheduled below, again determined by family size and income. The schedule discount percentage will be deducted from standard billing amounts for services provided.

2020 Sliding Fee Schedule Based on Federal Poverty Guidelines

Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
	Discount					
	Nominal Fee $40	80%	60%	40%	20%	None
Family Size	Income up to					At or Above
1	$ 12,760	$ 15,950	$ 19,140	$ 22,330	$ 25,520	$ 24,981
2	$ 17,240	$ 21,550	$ 25,860	$ 30,170	$ 34,480	$ 33,821
3	$ 21,720	$ 27,150	$ 32,580	$ 38,010	$ 43,440	$ 42,661
4	$ 26,200	$ 32,750	$ 39,300	$ 45,850	$ 52,400	$ 51,501
5	$ 30,680	$ 38,350	$ 46,020	$ 53,690	$ 61,360	$ 60,341
6	$ 35,160	$ 43,950	$ 52,740	$ 61,530	$ 70,320	$ 69,181
7	$ 39,640	$ 49,550	$ 59,460	$ 69,370	$ 79,280	$ 78,021
8	$ 44,120	$ 55,150	$ 66,180	$ 77,210	$ 88,240	$ 86,861
	For each additional person, add					
	$ 4,480	$ 5,600	$ 6,720	$ 7,840	$ 8,960	$ 8,840

*Based on 2020 HHS Poverty Guidelines https://aspe.hhs.gov/poverty-guidelines

Pediatric Associates

156 Island Creek Road
Pikeville, KY 41501

Phone 606-432-3221
Fax 606-432-8037

SLIDING FEE APPLICATION

It is the policy of Pediatric Associates to provide any essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including laboratory testing, drugs, and other such services. This form must be completed every 12 months or if your financial situation changes.

Name of Head of Household			Place of Employment	
Street	City	State	ZIP	Phone Number

PLEASE LIST SPOUSE AND DEPENDENTS UNDER AGE OF 18

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
TOTAL INCOME				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

NAME PRINTED

SIGNATURE

DATE

OFFICE USE ONLY

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

VERIFICATION CHECKLIST	YES	NO
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or unemployment verification		
Insurance: Insurance Cards		