Sliding Fee Scale Program

Frequently Asked Questions

Why should I apply?

You may qualify to pay a reduced visit fee when you come to a provider at Star Community Health

How much will it cost? There is no cost to apply for the program. The visit fees range from $10 - $30 per visit depending on your household size and income. You may also qualify for a minimum fee of $10 for dental services or reduced charges for dental services.

What is covered?

This program covers healthcare services provided by Star Community Health but does not cover visits to the hospital or other healthcare providers. You must apply at those places to participate in their programs. According to federal guidelines, Star Community Health is required to update our sliding fee scale program annually based on changes made to the federal poverty income levels. This takes place on May 1st of each year. Therefore, the program you qualify for may change at that time.

How do I apply?

Complete the application. Be sure to provide information for all your household members. Bring in or send us proof of income for all your income sources. If you are not sure what that means, there is a list of what we need for each kind of income on the application checklist.

Does this mean that I have insurance and won't have to pay a fine on my taxes?

No. This program is not considered to be health insurance coverage for tax purposes.

Can I use this program if I have health insurance?

Yes. If you qualify based on your household number and income and your health insurance has high deductibles or co-pays, you can still use this program to reduce your health care expenses. This is a discount program for services at Star Community Health.

What can the Health Care Marketplace do for you?

- New health insurance coverage options are available through PA Pennie.
- Low-cost and free plans are available and financial help is available based on how much money you make.
- No one can be denied coverage because they have a pre-existing condition.
- You may be eligible outside open enrollment if you have a life change such as marriage, relocation or the birth of a child, or if you lose your health insurance through job loss or losing Pennsylvania Medicaid

We can help! Call your Primary Care Office and ask for a Sliding Fee Application.

Sliding Fee Scale Program

Income Guidelines

Medical/Dental Services Sliding Fee Discount Schedule					
Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty					
Federal Poverty Income Levels 2022	**0% - 100%**	**101% - 125%**	**126% - 150%**	**151% - 200%**	**201% & Over**
Family Size					
1	$13,590	$16,988	$20,385	$23,783	$27,180
2	$18,310	$22,888	$27,465	$32,043	$36,620
3	$23,030	$28,788	$34,545	$40,303	$46,060
4	$27,750	$34,688	$41,625	$48,563	$55,500
5	$32,470	$40,588	$48,705	$56,823	$64,940
6	$37,190	$46,488	$55,785	$65,083	$74,380
7	$41,910	$52,388	$62,865	$73,343	$83,820
8	$46,630	$58,288	$69,945	$81,603	$93,260
For each additional person, add $4,720					
Patient Pays					
Medical Clinic	$10	$15	$20	$30	100% of Charge
Dental - Routine Care	$10	$15	$20	$30	100% of Charge
Dental - Non-Routine (% of Charges* plus Lab Fees **)	10%	15%	20%	30%	100% of Charge

*For non-routine procedures see the front desk receptionist at your dental office.

**Lab fees are charged at 100%. There is no discount for lab fees.

Sliding Fee Scale Program

Application

- A separate application is required for each member of the household who wants to participate in this program, including minor children. Only one set of supporting documentation is needed per household.
- You must complete all pages of the application form.
- If you need help, call [484-503-7827] ask for the Financial Counselors Office.

Last/First Name:		Social Security#	Date of Birth:
Mailing Address:	City:	St:	Zip Code:
Phone#	Message Phone# (Appt Reminders)	Do You have Health Insurance? **Yes No** If yes please list insurer and insurance ID #:	
Have You Applied to Pennsylvania Medicaid within the last year? **Yes No Unsure**	Circle One: **Have PA Medicaid** **Denied PA Medicaid Did Not Apply**		

It is necessary for Star Community Health to ask personal questions in order to determine if you are eligible for this program. This information will be kept on file in strict confidence. You must verify your income when you apply and once a year when your application is renewed. Copies of your yearly federal income tax return, payroll check stubs covering the last 4 weeks, Social Security benefit statements or other income sources are required. We cannot use bank statements for this purpose. Your annual income and household size will be used to determine your visit fee.

I declare the above information is true and give Star Community Health permission to investigate any information in this application.

I understand that:

- My information will be held in strict confidence.
- If this information is found to be false, I will lose my eligibility for the program and be liable to repay any benefit I have received.
- If my income or household size changes, I am required to notify the Billing Department as soon as possible.
- This application is to be returned before my next appointment or within 30 days, whichever is sooner, complete with proof of my annual income or this application will expire.
- I may reapply to the program at any time but reduced fees will apply only from the date of the new application.
- If I am found to be eligible for reduced fees but failed to make required payments, my account may be sent to a collection

I do hereby swear and attest that all the information above about me is true and correct.

Patient Signature:	Date: / /
Parent/Legal Guardian Signature:	Date: / /

Sliding Fee Scale Program

Application

Complete signed application for each applicant, listing all household members and income sources

Proof of income for each income source

If you have very low or no income, complete the "Zero Income Worksheet"

Most recent federal tax return if you file taxes

HOUSEHOLD: Please list all names and date of births for all members of your household including yourself.

If you file taxes your household is you, your spouse and any dependents you claimed on your taxes.

If you are claimed as a dependent by someone else, your household is you, the person who claims you and anyone else listed on their tax return.

If you do not file taxes and are not claimed as a dependent by anyone else, your household is you and your spouse and children if they live with you.

INCOME: You need to provide proof of income for each of the following sources of income for each member of your household to see if you qualify. Please note that we cannot accept bank statements as proof of income.

Employed: Pay stubs for the last four weeks OR federal tax return

Self-employment and Rental Income: you must provide a copy of your most recent federal tax return

Current Benefit Statement for:

Unemployment **Social Security** **TANF** **Worker's Compensation**
Long or short term disability **Child support/Alimony** **Retirement pension and or annuity**

Last Name	First Name	Date of Birth	Gross Income before Taxes and deductions	Relation	Income Source With Proof Attached
			$__ __ __,__ __._ _	Self	
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		

By signing below I declare that data and information listed above is accurate and true to the best of my knowledge and ability. I also certify that I have included all supporting documentation for each income source.

Patient Signature:	Date: / /
Parent/Legal Guardian Signature:	Date: / /

Sliding Fee Scale Program

Application

All person(s) that have provided you with assistance in the past 3 months (monetary or non-monetary), must complete the following charts and sign below to verify what assistance they have provided for you.

- If someone has given you money to pay for expenses below, indicate how much they have paid and write their name in the appropriate box.
- If someone has provided you any of the below expenses for free, please indicate free and put their name in the appropriate box.
- This page must be completed by each person who provided assistance to you in the last 3 Months.

Month #1	Month of:	
	Amount or	Who Assisted
Housing Expenses		
Utilities (water/sewer/electric/cable)		
Heat		
Food Expenses		
Transportation Expenses		
Cell Phone/Internet Expenses		
Medical Expenses		
Other Expenses		

Month #2	Month of:	
	Amount or	Who Assisted
Housing Expenses		
Utilities (water/sewer/electric/cable)		
Heat		
Food Expenses		
Transportation Expenses		
Cell Phone/Internet Expenses		
Medical Expenses		
Other Expenses		

Month #3	Month of:	
	Amount or free?	Who Assisted
Housing Expenses		
Utilities (water/sewer/electric/cable)		
Heat		
Food Expenses		
Transportation Expenses		
Cell Phone/Internet Expenses		
Medical Expenses		
Other Expenses		

*This form must be filled out completely; we will not be able to process your application if you leave parts of it blank. If you need to tell us more about your specific situation, please feel free to attach a letter or statement to this worksheet. If you receive assistance from other agencies, please attach copies of any assistance provided to you.

Printed Name and Signature of Person who provided you with assistance

Name:	Date: / /
Signature:	Date: / /

I do hereby swear and attest that all the information above about me is true and correct.

Patient Signature:	Date: / /
Parent/Legal Guardian Signature:	Date: / /

Sliding Fee Scale Program

Zero Income Worksheet

I, ______________________________________ certify that I have not received any income since ____/_____/_______.

Place(s) of last employment: ____

__ I am Full-Time Student over the age of 18.

Housing:

____ My own home/apartment — Do you receive housing assistance? Yes No

____ Someone else's home/apartment — Name of house/apartment owner: ____________________________________

____ Shelter/Transitional Housing

____ Other (explain): ____

Food:

Do you receive Food Stamps?

___ Yes (If Yes, you must attach a copy from DHHS.)

___ No

Transportation:

___ I have my own vehicle

___ A friend or relative provides me with transportation

___ I use public transportation

Communication Expenses:

Do you have a cell phone? Yes No — If Yes, who pays for your cell phone? ____

Please provide a brief description of your current financial situation: ____

____

____

____

I do hereby swear and attest that all the information above about me is true and correct

Patient Signature:	Date: / /
Parent/Legal Guardian Signature:	Date: / /

STAR COMMUNITY HEALTH

Sliding Fee Scale Program

Declaration of Income Statement

I, ______________________________________ certify that I have received income since ____/_____/_______ from place of employment: ____Phone#: ____________________________. I certify that I am unable to produce the required documentation of income, however I hereby authorize Star Community Health to contact my place of employment and verify income verbally. I understand that I maybe asked to apply for health insurance through the market place or state/federal sources. I understand that Star Community Health may ask for supporting documentation and will comply with such requests. I also certify that the information contained on this form and application are true, and should Star Community Health find them to be false I maybe held liable for all of the charges associated with my healthcare.

Housing:

____ My own home/apartment Do you receive housing assistance? Yes No If Yes Amount: _______________________

____ Someone else's home/apartment Name of house/apartment owner: ____________________________________

____ Shelter/Transitional Housing

____ Other (explain): ____

Income:

Hourly Wage: $_______.____/hr I am paid every ____ 1 Week, ___ 2 Weeks, ____ Monthly.

I receive my wages in the form of ____ Cash, ____ Check, or ____ Direct Deposit.

Taxes are withheld from my wages ___ Yes ___ No

Transportation:

___ I have my own vehicle

___ A friend or relative provides me with transportation

___ I use public transportation

Please provide a brief description of your current financial situation: ____

____

____

____

Applicant must still complete the application in addition to this form

I do hereby swear and attest that all the information above about me is true and correct.

Patient Signature:	Date: / /
Parent/Legal Guardian Signature:	Date: / /

Sliding Fee Scale Program

Waiver of Payment

I, ____________________________________ certify that I am having difficulty meeting my financial obligations to Star Community Health and am requesting that the fee of $__________ be waived during the time frame below. I understand that this fee is waived only after meeting with a Financial Counselor and being approved for the waiver. I also understand that I will have continue to meet with the Financial Counselor at each appointment that I have at Star Community Health either prior to or after appointment to provide updates of financial situation. I understand that this waiver can be cancelled by Star Community Health if I do not complete the requirements of meeting with the Financial Counselor.

Please provide a brief description of your current financial situation: ____

____

____

____

****Financial Counselor Use Only****

Financial Counselor Name:___________________________________ Date: ____/____/______

Medical Record Number: _______________________ Patient Name: _______________________________ DOB: ___/___/_____

Waiver approved starting ____/____/_______ and ends on ___/____/_____.

Patient will meet with the Financial Counselor on the following dates:

___/____/_____ ___/____/_____ ___/____/_____ ___/____/_____ ___/____/_____

___/____/_____ ___/____/_____ ___/____/_____ ___/____/_____ ___/____/_____

The patient must present a copy of this form to the registration staff at time of appointment in order to receive the waiver of the fee.

I do hereby swear and attest that all the information above about me is true and correct

Patient Signature:	Date: / /
Parent/Legal Guardian Signature:	Date: / /

Financial Counselor Signature:	Date: / /

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Declination Statement

Last/First Name:			Social Security#		Date of Birth:	
Mailing Address:		City:		St:	Zip Code:	
Phone#	Message Phone# (Appt Reminders)					

☐ I Do not wish to comply with or apply to the sliding scale requirements.

Because you do not wish to apply or comply with the requirements to apply for our sliding fee scale discount, you are choosing to be a self pay patient. This means that you will pay $75.00 up front at the time of service and you will be responsible for any and all balances due after the provider's charges for your visit are entered. You will also be responsible for any lab and/or x-ray/diagnostic charges for today's visit. Any discount for office charges or lab charges are not applicable and you will not receive a discount for these charges in the event that a future sliding scale application is completed.

Patient Signature:	Date: / /
Parent/Legal Guardian Signature:	Date: / /

Sliding Fee Scale Program

OFFICE USE ONLY

Application Date: _____/_____/______ Financial Counselor: ____

First Review: _____/_____/______ Second Review: _____/_____/______ Third Review: _____/_____/______

Item	Complete	Incomplete
Information is not legible Specify Page#		
Page 1 is not signed or is incomplete		
Page 2 is not signed or is incomplete		
3 months of pay stubs		
Federal Tax Return		
Self-employed/Rental Income or Schedule C tax form		
Unemployment, SSI, TANF, Workers Comp, Disability, Child/Alimony Support, Retirement/Pension and or annuity		
Page 3 is not signed or is incomplete		
Person completing the form did not sign attestation		
Month #_____ is missing information		
Page 4 is not signed or is incomplete		
Other Housing is checked but no explanation provided		
Cell phone is marked yes but no explanation as to who pays for it		
Brief description of financial situation is not complete		
Photo Id Scanned into EPIC		
Insurance Card(s) Scanned into EPIC		
Application Status updated in EPIC		
Application Scanned Into EPIC		

This Application has been:

_______ Approved as of _____/_____/______, application expires on: _____/_____/______

______ Denied as of _____/_____/______ because of:

____

____

I have reviewed this information and based the decision above solely on the information contained in this application

Counselor Signature:	Date: / /