Sliding Fee Discount Application

If you wish to qualify for the sliding fee, you MUST show proof of income for all family members/individuals living in your household or individuals for whom you are financially responsible. If you do not have any source of income, please speak with a staff member. Applicants should provide a copy of either:

- Two consecutive pay stubs for each employed adult age 18 and over living in the household, or living outside the household but for whom the household is financially responsible
- Previous year's tax return or W-2 for each adult living in the household or for whom the the household is financially responsible (Income will come from Gross Income line on respective tax return)

Name: ______________________

Date of Birth: ______________________

Family Size: ________
(Number of family members living in your household.)

List name(s) and date(s) of birth of family members/individuals living in your household or individuals for whom you are financially responsible.

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Address: ______________________

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Phone: ______________________

DISCLAIMER:
I hereby certify that the above information is, to the best of my knowledge, true and correct. I further agree to notify The Primary Health Network of any changes in this information within ten (10) days of such change.

I understand that I must re-qualify annually to maintain my eligibility.

I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government.

Sliding Fee payment is due and payable at the time of service. To maintain discount, fees must be paid promptly. If you are unable to make payment at time of service, please speak to the receptionist to make other arrangements.

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Signature of patient or responsible party

Determining Eligibility

Primary Health Network, Inc. is a Federally Qualified Health Center. We are able to offer a discount on some services based on a household's income and size. Sliding fee calculations are determined by using Federal Income Tax forms, W-2's, or last two consecutive pay stubs. The staff at PHN then uses the table on the inside of this brochure to determine your eligibility.

Your household discount will be assessed on a yearly basis.

PLEASE NOTE: There is a minimum charge for some procedures, labs and medications.

If you have any questions, please contact the PHN Billing Department at 724-342-5313 or email billing@primary-health.net

Return completed application to:
P.O. Box 716
Sharon, PA 16146

TO BE COMPLETED BY PHN STAFF

Annual Gross Income $ ______________

Patient is eligible for sliding fee discount in category ______________

☐ Proof of income verified.
☐ Patient refused to complete.
☐ Patient does not qualify for sliding fee.

______________ ______________
Verified By Date

PHN Sliding Fee

The Primary Health NETWORK

Embracing Excellence in Healthcare

www.primary-health.net

Sliding Fee Discount

Sliding Fee Scale

(Based on Federal Register 2016 - Poverty Income Guidelines)

Family Size	Income Measure	Category 0	Category 1	Category 2	Category 3	Category 4
% of Federal Poverty Income Guidelines		Up to 100%	100.01% – 149.99%	150.00% – 174.99%	175.00% – 200.00%	200.01% +
Per Diem		$0	$30	$40	$50	
1	Annual Monthly	$0 – $11,880 $0 – $990	$11,881 – $17,819 $991 – $1,484	$17,820 – $20,789 $1,485– $1,732	$20,790 – $23,760 $1,733 – $1,979	$23,761 + $1,980 +
2	Annual Monthly	$0 – $16,020 $0 – $1,335	$16,021 – $24,029 $1,336 – $2,002	$24,030– $28,036 $2,003 – $2,335	$28,037 – $32,040 $2,336 – $2,669	$32,041 + $2,670 +
3	Annual Monthly	$0 – $20,160 $0 – $1,680	$20,161 – $30,239 $1,681 – $2,519	$30,240 – $35,281 $2,520 – $2,939	$35,282 – $40,320 $2,940 – $3,359	$40,321 + $3,360 +
4	Annual Monthly	$0 – $24,300 $0 – $2,025	$24,301 – $36,449 $2,026 – $3,037	$36,450 – $42,526 $3,038 – $3,543	$42,527 – $48,600 $3,544 – $4,049	$48,601 + $4,050 +
5	Annual Monthly	$0 – $28,440 $0 – $2,370	$28,441 – $42,659 $2,371 – $3,554	$42,660 – $49,771 $3,555 – $4,147	$49,772 – $56,880 $4,148 – $4,739	$56,881 + $4,740 +
6	Annual Monthly	$0 – $32,580 $0 – $2,715	$32,581 – $48,869 $2,716 – $4,072	$48,870 – $57,016 $4,073 – $4,750	$57,017 – $65,160 $4,751 – $5,429	$65,161 + $5,430 +
7	Annual Monthly	$0 – $36,730 $0 – $3,061	$36,731 – $55,094 $3,062 – $4,591	$55,095 – $64,278 $4,592 – $5,356	$64,279 – $73,460 $5,357 – $6,121	$73,461 + $6,122 +
8	Annual Monthly	$0 – $40,890 $0 – $3,408	$40,891 – $61,334 $3,409 – $5,111	$61,335 – $71,558 $5,112 – $5,962	$71,559 – $81,780 $5,963 – $6,814	$81,781 + $6,815 +
*each additional family member		+ $4,160 A / $347 M	+ $4,160 A / $347 M	+ $6,240 A / $521 M	+ $6,289 A / $606 M	+ $8,362 A / $697 M

Exclusions - Category 0

The following will be billed at actual cost:

- **Lab**
- **Medical devices**
- **Injectables**

Exclusions - Category 1-3

- **Lab costs**
- **Some in-office surgeries/procedures**
- **Injectables do not apply**
- **No offsite services are eligible, such as:**
  - **Hospital**
  - **Hospital Services**
  - **Nursing Homes**