Exhibit B

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Information: _____ MR#_____

It is the policy of VCCHC to provide 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 to determine if you or members of your family are eligible for a discount under VCCHC's sliding fee discount program.

Covered Services: Are those provided at the clinic within VCCHC's scope of project (Form 5A) and, included in Nominal Fee is: Examination/Consultation for all services within VCCHC's scope of project (Form 5A), In-house laboratory, Other in-house procedures and authorized send out laboratory specimens drawn at the clinic for analysis(see lab formulary) and routine injectables/immunizations (Flu shot, TD, PPD).

NOTE: Proof of income is required before a discount is approved. Below are some items that will qualify as proof of income AND you have **30 days** from the date above to provide the proof of income.

- Two most current pay stubs for all members in the household
- Most current year's income tax return if filed jointly and dependents claimed. If not, then each individual tax return.
- Social Security Check Stubs
- Unemployment Income letter/check, Public Assistance letter or check
- Other independent form of evidence.
- Alimony/Child support (court order, etc.)
- Letter from current employer stating annual income
- Self-Declaration of Income Form
- Rental Income ((lease/rental agreement)
- Self Employed: three (3) months of income and expenses or most current year business tax return.

Please list yourself, your spouse, and any dependents regardless of age:

Name	Relationship	Date of Birth
1)Self:		
2)*Spouse:		
3)*Dependent:		
4)*Dependent:		
5)*Dependent:		
6)*Dependent:		
7)*Dependent:		
8)*Dependent:		
9)*Dependent:		

Total Family Size: _____ (include yourself)

Family/household Size: * Dependent: spouses, registered domestic partners, parents, or children (includes biological, adopted, foster, step, legal ward, or child of a registered domestic partner); all such people are considered as members of one family regardless of age living in the household, if they are dependent upon the family for more than 50% of their support. Any other dependent that may not be listed above, but who is claimed on a tax return (tax return required).

Income Calculation:

Income: ALL sources and forms of revenue/earnings/income (before taxes/gross/total income, e.g. line 22 of Form 1040/line 15 of Form 1040A/adjusted gross income line 4 of 1040EZ and **Line 7 for 2018** redesigned 1040 (adjusted gross income or AGI)) (For Tax Year 2018, **you will no longer use Form 1040A or Form 1040EZ)** earned or received by an individual or family in the household. Examples of income include but are not limited to: self-employment earning (net of business expenses), unemployment, gross employment earnings, tips, child support, alimony, interest, dividend, retirement/pension or social security income, student support income, welfare or other public assistance payments, veterans payments, survivor benefits, pension or retirement income, rental income, royalties, income from estate or trusts, educational assistance, assistance from outside the household, and other miscellaneous source, etc.

Name	Source	Amount	**Frequency
Total Income (add each column):			

****Frequency: Daily, Weekly, Bi-Weekly (every two weeks), Semi-Monthly (twice a month), Monthly, Other**

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

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 certify that the family size and income information shown above is correct. I further understand that any change in financial status or the number of people in my household must be reported immediately to VCCHC and a new application must be completed. I understand that upon request of VCCHC there will be a review of my application with the possibility of discount percentage changes. I understand that any falsifications or the failure to report any changes may result in my being made ineligible for the Sliding Fee adjustments made available by the VCCHC.

Name (Print) _____Signature _____Date _____

OFFICE USE ONLY

Patient Name: _____Sliding Fee Scale %: _____

Approved By (signature/Name/Title: _____

Date Approved: _____ Date Expired: _____

Verification Checklist	Yes	No
Proof of Identity and Address:		
Required-Proof of Income (specify type):		
Existing Insurance: Copy of Insurance Cards and Eligibility Screening		

Exhibit C

Abilities to Pay-Pending Verification of Income

Self-Declaration by patient regarding financial abilities to pay for care, and income & family size self-declaration.

Patient Name:_____

Family Size:_____**Date:**_____

I certify that I am unable to provide a check stub and that my monthly income is:

$_____

During the next visit I will provide verification of my address and of my income.

This verification is for the purpose of obtaining medical services at VCCHC. The undersigned hereby certifies the following:

- **I am head of household**
- **I am self-employed**
- **I receive cash payments from my employer**
- **I do not work but I am supported by my spouse's income**
- **I receive Unemployment/Disability/Social Security Benefits**
- **I receive AFDC/ Welfare**

I declare that I do not have any type of medical insurance that could pay for my medical services and the information I have provided is correct. I also understand that once I am assigned to sliding fee scale I will be charged at every visit once approved. The cost of the visit may vary depending on what the Dr. deems necessary for my healthcare unless you are at 100%. Laboratory work is **not** included in the charge of the visit. Please stop back to the front to pay your balance. On your next visit please bring with you your correct address and income verification. You have **30 days** from date of this visit to provide acceptable proof of income.

I have been informed that I qualify for the following sliding fee scale:

☐ **<=100%-A*** ☐ **<125%-B** ☐ **<150%-C** ☐ **<175%-D** ☐ **<=200%=E** ☐ **>200%-F (no discount)**

Patient Signature:_____Date_____

Staff Signature:_____Date:_____

Exhibit D

Hardship Waiver or Reduction of Payment

Sir/Madam _____ Date _____

Thank you for providing a Hardship Letter documenting your situation.

___ At this time, we have determined you are not eligible for a hardship waiver.

At this time, we have determined you are eligible for:

___ 1) a full waiver of charges

___ 2) a reduction/discount of _____% of full charges.

The Waiver/Reduction is approved for the following period _____ to _____ (and cannot exceed one year) and only applies to services provided by VCCHC and does not include medically unnecessary, optional, or cosmetic services.

Should your circumstance change and you need to speak to our Enrollment Specialist or Billing Manager and provide them with your updated information. Please do not hesitate to contact our office. Thank you for choosing VCCHC and entrusting us with your health care.

Prepared & reviewed by: _____ (Enrollment Specialist)

Signature: _____ Date: _____

Approved by: _____ (Billing Manager or Finance Director)

Signature: _____ Date: _____

Exhibit E

Acceptable Life Changing Events for Hardship Reduction or Waiver to SFDP

• Death of a family member or close friend • Personal Injury or Illness • Dependent Injury or Illness • Dismissal from work for self or spouse • Retirement • Marriage • Divorce • Marital Separation • Marital Reconciliation • Imprisonment • Pregnancy • Gain of a new family member	• Business readjustment • Purchase of a new home • Foreclosure of mortgage or loan • Change in residence, school, or work • Change in financial state • Change in living conditions- lose of home, eviction • Depression, Anxiety, PTSD • Becoming the victim of a crime • Child leaves home • Start or end of school • Military Leave • Business readjustment • Purchase of a new home

Exhibit F

NOTICE TO PATIENTS:

This practice serves all patients regardless of inability to pay. Discounts for essential services are offered based on family size and income. For more information, ask at the front desk or visit our website. Thank you.

AVISO PARA PACIENTES:

Esta práctica sirve a todos los pacientes, independientemente de la incapacidad de pago. Descuentos para los servicios esenciales son ofrecidos dependiendo de tamaño de la familia y de los ingresos. Usted puede solicitar un descuento en la recepción o visita nuestro sitio web.
Gracias.

Exhibit G

Advance Beneficiary Notice of Noncoverage (ABN) NOTE:

Patient Name:_____ **MR#**_____

If my insurance (third party payor) doesn't pay or the sliding fee discount program that I'm eligible for does not include the services/medication/supplies/etc. in A below, I understand I have to pay.

A: NOT COVERED:

B: ESTIMATED COST
$ _____

Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the A listed of items above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance.

OPTIONS: Check only one box. We cannot choose a box for you.

□ **OPTION 1**. I want the **A** listed above. You will ask to be paid now, but I also want third party payor billed for an official decision on payment, which is sent to me by the payor. If third party pays, you will be refund any payments you made to LBCC, less co-pays or deductibles.

□ **OPTION 2**. I want the **A**. listed above, but do **not** bill my third-party payor (including Medicare). You will be asked to pay now as I am responsible for payment. (note: I cannot appeal if Medicare is not billed).

□ **OPTION 3.** I **don't want** the **A**. listed above.

Signing below means that you have received and understand this notice. You may request a copy

Patient Signature: _____ Date: _____

Exhibit H

SELF-DECLARATION of INCOME AND FAMILY SIZE

Name: _____	DOB: _____

The following information is true and correct to the best of my knowledge and belief.
I am currently unemployed and have no source of income; I am living off my savings account; I am a student receiving a student grant/loan; I receive cash payment for work performed. Other reason:_____
_____

Position title or type of work being performed: _____

Frequency of pay and amount, please complete **one** of the below:

$ _____ Hourly	$ _____ Bi-Weekly (14 Days)
$ _____ Daily	$ _____ Semi-Monthly (2x Month)
$ _____ Weekly	$ _____ Monthly

Family Size (including yourself):_____

Applicants must read the following and sign below:
I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for public health insurance programs. I understand that program officials may verify information on this form. I also understand that if I intentionally misrepresent my income, I may have to repay benefits received and may be prosecuted under State law.

Signature of Applicant: _____ Date: _____

OFFICE USE ONLY: Enrollers must read the following and sign below. I certify that I asked the applicant/recipient about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me. I did not modify the information in any way. I understand that if I intentionally falsified information on this form or if I assisted the applicant in falsifying any information, I may lose my job and may be prosecuted under State law.

Name: _____ Signature: _____ Date: _____