SLIDING FEE PROGRAM

What is the Sliding Fee Program? The Sliding Fee Program is a federally funded program that provides a discount to patients who are uninsured or under-insured. This program allows eligible patients to receive primary medical care, mental health and/or qualifying dental services at Battenkill Valley Health Center (BVHC). Qualifying services at Southern Vermont Medical Center (SVMC), Rutland Regional Medical Center (RRMC), and United Counseling Services, LLC. are also available at a discounted rate after any insurance, if applicable, has been processed. There is a minimum co-payment due at the time of service for all discounted services received.

Who is eligible for the Sliding Fee Program? Uninsured and under-insured patients may qualify for the Sliding Fee Program. Based on current National Poverty guidelines, patients may be eligible for financial assistance based on household size and household income.

Do local hospitals offer Sliding Fee Programs? Whether you qualify or not for BVHC’s Sliding Fee Program, you may qualify for the Charity Care Programs for services provided by Rutland Regional Medical Center or Southwestern Vermont Medical Center. BVHC has agreements with RRMC and SVMC to provide patients who are eligible to be the beneficiary of the better of the two programs. The services covered within the Sliding Fee Programs at RRMC and SVMC include but are not limited to the following:

- RRMC
  - Diagnostic laboratory
  - Diagnostic Imaging
  - Emergency Care
  - Inpatient Care
  - Hospitalist Services for adult care
  - Rehabilitation Care
  - Obstetrical Care
  - Specialist and subspecialty care

- SVMC
  - Diagnostic laboratory
  - Diagnostic Imaging
  - Emergency Care
  - Inpatient Care
  - Hospitalist Services for adult and pediatric care
  - Rehabilitation Care
  - Obstetrical Care
  - Specialist and subspecialty care
  - Translation Services

BVHC will reimburse United Counseling Services, LLC for patients who BVHC refers for mental health services.

When should you apply for the Sliding Fee Program? You should apply immediately to see if you qualify for the Sliding Fee Program. If approved for the program, you will be required to renew your application every six months. If you are not approved for the program, you are encouraged to contact us if you have a significant change in income or family size as we may be able to re-evaluate your information.

How can you apply for the Sliding Fee Program?

- Complete and sign the Sliding Fee Program Application (enclosed)
- Proof of Income – Please attach supporting documentation for any/all of the below sources of income (i.e. most recent W2, two (2) most recent pay stubs, proof of child support or other income sources by canceled check)
- Income is defined as the combined, before-tax (gross) money received by all relatives residing in the home. This income would include wages and salaries, unemployment insurance, disability, child support, pensions, trust account payments, and any other similar type of income. (Households claiming zero income will be required to schedule an appointment with one of our eligibility staff members to assess if a discount can be determined)
- A household member is defined as any person that spends at least 50% of his/her time living in the home and is related to the head of household. Patients living in the same home, who do not file joint tax returns and are not responsible for each other’s bills may apply separately and qualify separately for sliding fee scale discounts.

Enclosed is an application for the Sliding Fee Program. If you believe that you are eligible, please complete, sign and return your application with proof of income to BVHC. Once received, your completed application will be reviewed by the Practice Administrator who will then send you a letter regarding your eligibility. Keep in mind, if you are accepted into the Sliding Fee Program, discounts will only apply to services received from the date of your application through the 6 month approval period.

All of the required information must be received in order to process your application. Until you receive a letter indicating you have qualified for a discount, you are responsible for 100% of all charges. If and when you are approved, payment within 30 days of receiving a statement must be submitted to BVHC. If you are unable to make payment within 30 days, you can ask to meet with the Practice Administrator to set up a payment plan. Patients who fail to make payments per the terms and conditions of the payment plan will be put on same-day status. Patients on same-day status will be unable to schedule appointments; they will be seen for acute (sick) visits only, and must wait in the waiting room for an open appointment. Patients will be released from same-day status only after their balance is paid in full.

Patients who qualify for the Sliding Fee Program and who cannot afford the nominal fee will submit an explanation in writing for review by the Finance Department which will provide recommendations to the Clinical Director. The Clinical Director, or in her/his absence the Project Director, is authorized to waive nominal fees on a case-by-case basis. Waivers for nominal fees will be approved for patients who can demonstrate situational hardship and, if applicable, steps they are taking to address the hardship.
Federal Poverty Guidelines: Effective January 2018

BVHC Sliding Fee Scale: Effective June 22, 2018

<table>
<thead>
<tr>
<th>Size of Family</th>
<th>Full Subsidy</th>
<th>101% - 125%*</th>
<th>126% - 150%*</th>
<th>151% - 175%*</th>
<th>176% - 200%*</th>
<th>Full Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$0 - 12,140</td>
<td>$12,141 - $15,175</td>
<td>$15,176 - $18,210</td>
<td>$18,211 - $21,245</td>
<td>$21,246 - $24,280</td>
<td>Over $24,281</td>
</tr>
<tr>
<td>3</td>
<td>$0 - 20,780</td>
<td>$20,781 - $25,975</td>
<td>$25,976 - $31,170</td>
<td>$31,171 - $36,365</td>
<td>$36,366 - $41,560</td>
<td>Over $41,561</td>
</tr>
<tr>
<td>4</td>
<td>$0 - 25,100</td>
<td>$25,101 - $31,375</td>
<td>$31,376 - $37,650</td>
<td>$37,651 - $43,925</td>
<td>$43,926 - $50,200</td>
<td>Over $50,201</td>
</tr>
<tr>
<td>5</td>
<td>$0 - 29,420</td>
<td>$29,421 - $36,775</td>
<td>$36,776 - $44,130</td>
<td>$44,131 - $51,485</td>
<td>$51,486 - $58,840</td>
<td>Over $58,841</td>
</tr>
<tr>
<td>6</td>
<td>$0 - 33,740</td>
<td>$33,741 - $42,175</td>
<td>$42,176 - $50,610</td>
<td>$50,611 - $59,045</td>
<td>$59,046 - $67,480</td>
<td>Over $67,481</td>
</tr>
<tr>
<td>7</td>
<td>$0 - 38,060</td>
<td>$38,061 - $47,575</td>
<td>$47,576 - $57,090</td>
<td>$57,091 - $66,605</td>
<td>$66,606 - $76,120</td>
<td>Over $76,121</td>
</tr>
<tr>
<td>8</td>
<td>$0 - 42,380</td>
<td>$42,381 - $52,975</td>
<td>$52,976 - $63,570</td>
<td>$63,571 - $74,165</td>
<td>$74,166 - $84,760</td>
<td>Over $84,761</td>
</tr>
<tr>
<td>9</td>
<td>$0 - 46,700</td>
<td>$46,701 - $58,375</td>
<td>$58,376 - $70,050</td>
<td>$70,051 - $81,725</td>
<td>$81,726 - $93,400</td>
<td>Over $93,401</td>
</tr>
<tr>
<td>10</td>
<td>$0 - 51,020</td>
<td>$51,021 - $63,775</td>
<td>$63,776 - $76,530</td>
<td>$76,531 - $89,285</td>
<td>$89,286 - $102,040</td>
<td>Over $102,041</td>
</tr>
<tr>
<td>each add'l member add</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 4,320</td>
<td>$ 5,400</td>
<td>$ 6,480</td>
<td>$ 7,560</td>
<td>$ 8,640</td>
<td></td>
</tr>
</tbody>
</table>

$20 med fee 20% balance 40% balance 60% balance 80% balance
$40 den fee 35% of procedure 45% of procedure 60% of procedure 80% of procedure
100% of labs fees, 100% of labs fees, 100% of labs fees, 100% of labs fees, 100% of labs

MEDICAL
1. A nominal fee of $20 for medical visits will be collected at the time of service for all patients on full or partial subsidy. For patients on partial subsidy, their percentage based balance will be billed to them.
2. If a patient presents with no conclusive proof of income to establish their sliding fee scale eligibility, the patient will be placed on full payment until proof is established.

DENTAL
1. A nominal fee of $40 for dental services, plus 100% of lab fees is expected at the time of service for patients on full subsidy.
2. Patients on partial subsidy are responsible for their percentage of procedure fees, plus 100% of the cost of their lab fees, which is expected at the time of service.
3. Patients on partial subsidy will pay either their discounted percentage of procedure fees, or $40, whichever is greater.
4. If a patient presents with no conclusive proof of income to establish their sliding fee scale eligibility, the patient will be placed on full payment until proof is established.
5. Certain dental procedures do not qualify for sliding fee discount.

* Federal Poverty Limit
**Battenkill Valley Health Center**  
**Application for Sliding Fee Program**

*Return to the office with proof of income and proof of physical address*

1. **Applicant**
   - Name (Last) ___________________________________ (First) ___________________________________ (MI) _______
   - Physical Address ________________________________ City __________________ State _____ Zip _______
   - Preferred Phone ________________________________ Date of Birth __ Date of Birth ______ SS# __________
   - Single □ Married □ Divorced □ Widowed □ Separated □ Civil Union

2. **Household Members** (Include spouse, dependent children, relatives and others that live with you)
   - Name ___________________________ Relationship ___________________________ Birth Date __________ Social Security # __________
   - 1. ______________________________________________________________________________________
   - 2. ______________________________________________________________________________________
   - 3. ______________________________________________________________________________________
   - 4. ______________________________________________________________________________________
   - 5. ______________________________________________________________________________________

   **Have you applied for State Healthcare?** □ Y □ N  
   **Are you homeless/doubling up?** □ Y □ N
   **Results of application:** ____________________________  
   **Are you a tourist or foreign student?** □ Y □ N
   **Are you a College/University student?** □ Y □ N
   **If yes, can you be claimed as a dependent on someone else’s tax return?** □ Y □ N *(If yes, additional income verification is required)*

3. **Total Income of Family** (anyone on your income tax return)
   - Total Household Members: __________
   - Wages/salary $__________ per □ hour □ biweekly □ monthly □ annually
   - From sections 1 & 2 __________
   - Self-employment $__________ per □ hour □ biweekly □ monthly □ annually
   - Type of work __________________________
   - Unearned $__________ per □ hour □ biweekly □ monthly □ annually
   - Total Annual Income $__________

4. **Insurance**
   - Do you or your spouse have medical insurance benefits? □ Y □ N
   - Employer __________________________________________________________

5. **Signature**
   - To the best of my knowledge, the above information is true and correct. I agree to inform BVHC of any changes in employment or financial status for anyone listed on this application. If the above information proves to be incorrect, I understand that the discount provided to me will be terminated. (I also give permission for the BVHC staff to contact my employer or any other source to verify income.)

   ______________________________________________________________________
   **Signature of Applicant** ____________  
   **Date** ____________

---

**FOR BVHC USE ONLY**

**Authorizer Initials** ____________  
**Fee Level** ____________  
**Approval/Denial** ____________  
**Date** ____________  
**Expiration Date** ____________