ConnextCare
A Community of Care

61 Delano Street, Pulaski, New York 13142-1400
Phone (315) 298-6564 Fax (315) 298-7488 TDD: 711
www.connextcare.org

SLIDING FEE SCALE PROGRAM

ConnextCare offers a **Sliding Fee Scale Program**, which can reduce the cost of your care based on your household income. If you have insurance, we will apply the discount to the portion you are responsible for paying. Once approved, your sliding fee coverage is valid for one year, and you must re-certify annually to maintain eligibility.

For patients without insurance, the program may also help cover a portion of medical lab and pharmacy costs. Please note that laboratory services must be completed through Oswego Hospital Laboratories, and all prescriptions and lab work must be ordered by a ConnextCare provider.

If you are eligible for patient assistance programs for medications, you are required to apply. Medicare patients age 65 and older must also enroll in EPIC, New York State's prescription plan for seniors. Through the Sliding Fee Scale Program, ConnextCare will reimburse a portion of your EPIC annual fee and prescription co-pays based on your discount level. For example, if you qualify for a 75% discount, you will be reimbursed for 75% of your EPIC fees and co-pays.

Reimbursement requests can be submitted at any time using a form available from our Outreach and Access Representatives. However, reimbursement checks are issued quarterly—at the end of March, June, September, and December - for all eligible receipts submitted to date.

To determine if you may qualify, please review the income chart below. If your household income falls within the guidelines for your household size, complete the application on the reverse side and bring it to the front desk at any ConnextCare health center. Our staff will schedule an appointment with an Outreach and Access Representative. You may also mail your completed application and income verification to the address listed above, and we will contact you to schedule an appointment.

If you have questions or need assistance, please call our Pulaski location at 315-298-6564 and ask to speak with an Outreach and Access Representative.

All sliding fee patients are asked to pay a nominal visit fee of $15.00.

Household Members	Medicaid Eligible	75% discount	50% discount	25% discount
1	0 - 15,960	15,961 - 21,281	21,282 - 26,602	26,603 - 31,920
2	0 - 21,640	21,641 - 28,854	28,855 - 36,069	36,070 - 43,280
3	0 - 27,320	27,321 - 36,428	36,429 - 45,535	45,536 - 54,640
4	0 - 33,000	33,001 - 44,001	44,002 - 55,002	55,003 - 66,000
5	0 - 38,680	38,681 - 51,574	51,575 - 64,469	64,470 - 77,360
6	0 - 44,360	44,361 - 59,148	59,149 - 73,935	73,936 - 88,720
7	0 - 50,040	50,041 - 66,721	66,722 - 83,402	83,403 - 100,080
8	0 - 55,720	55,721 - 74,294	74,295 - 92,869	92,870 - 111,440
9	0 - 61,400	61,401 - 81,868	81,869 - 102,335	102,336 - 122,800
10	0 - 67,080	67,081 - 89,441	89,442 - 111,802	111,803 - 134,160
11	0 - 72,760	72,761 - 97,014	97,015 - 121,269	121,270 - 145,520
12	0 - 78,440	78,441 - 104,588	104,589 - 130,735	130,736 - 156,880

APPLICATION FOR SLIDING FEE SCALE ADJUSTMENT

PLEASE BRING VERIFICATION OF INCOME

Please see attached checklist for acceptable forms of verification.

Say hello to healthy

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1. NAME: _____
First Middle Last

ADDRESS: _____
Number and Street City State Zip

TELEPHONE: _____

2. **CURRENT EMPLOYER:** _____

ADDRESS & PHONE #: _____

Or, Are you homeless? Yes_____ No_____
If yes - What is your current status:
☐ Homeless shelter ☐ Transitional ☐ Doubling up ☐ On the street

3. Are you a veteran? Yes_____ No_____
4. Do you live in public housing? Yes_____ No_____
5. **INCOME**: List income for the household from:

	Current Monthly	Last 12 Month Total
Wages or self-employed.....	_____	_____
Public Assistance or Social Security.....	_____	_____
Unemployment or Workmen's Comp.....	_____	_____
Alimony or Child Support.....	_____	_____
Pensions/Annuities.....	_____	_____
Income from rent, dividends, interest, or any other source	_____	_____

6. Do you have any other insurance?..... _____
If so, what kind?..... _____
Identification #..... _____

7. **HOUSEHOLD SIZE**:

NAME	RELATIONSHIP	DATE OF BIRTH
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of the Applicant _____Date _____

FOR OFFICE USE ONLY
Qualifies for: _____ *% Discount* _____ *Ineligible Date of determination:* _____

Signature: _____

Say hello to healthy

Fulton / Mexico / Oswego / Phoenix / Pulaski / School-Based Health Centers