

SLIDING FEE SCALE PROGRAM

ConnexCare offers a sliding fee scale. This means we can reduce your charges for services based upon your household's income. If you have insurance, we will adjust only the portion that you must pay. Once approved for sliding fee, your coverage is valid for one year. You must re-certify every year to maintain your coverage.

Our sliding fee scale program will also pay a portion of your medical lab and pharmacy bills if you have no insurance coverage. This laboratory benefit is only available for lab work done through Oswego Hospital Laboratories. A provider of ConnexCare must order prescriptions and lab work.

If you are eligible for patient assisted medicine, we do require you to apply. All Medicare applicants who are 65 or older will be required to enroll in EPIC, New York State's prescription plan for seniors. The sliding fee program will reimburse you for EPIC's annual fee and all prescription co-pays at the level of program discount. For example, if you qualify for 75% sliding fee, we will reimburse you 75% of your annual fee and co-pays. A form is available from our Outreach and Access Representatives to submit receipts for reimbursement. Receipts may be submitted at any time; however we will only send checks quarterly. Reimbursement checks will be issued at the end of March, June, September and December for all receipts submitted to date.

Please check the income chart below. If your gross yearly household income appears on the line that shows your household size, you may be eligible for reduced charges. Complete the application form on the reverse side and bring it to the front desk at one of our health centers so that we can set up an appointment for you with one of our Outreach and Access Representatives. You may also mail the form with necessary income verification to the address above and we will contact you to set up an appointment. If you have any questions you can call the **Pulaski location at 298-6564 and ask to speak with our 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 - 12,880	12,881 - 17,174	17,175 - 21,469	21,470 - 25,760
2	0 - 17,420	17,421 - 23,228	23,229 - 29,035	29,036 - 34,840
3	0 - 21,960	21,961 - 29,281	29,282 - 36,602	36,603 - 43,920
4	0 - 26,500	26,501 - 35,334	35,335 - 44,169	44,170 - 53,000
5	0 - 31,040	31,041 - 41,388	41,389 - 51,735	51,736 - 62,080
6	0 - 35,580	35,581 - 47,441	47,442 - 59,302	59,303 - 71,160
7	0 - 40,120	40,121 - 53,494	53,495 - 66,869	66,870 - 80,240
8	0 - 44,660	44,661 - 59,548	59,549 - 74,435	74,436 - 89,320
9	0 - 49,200	49,201 - 65,601	65,602 - 82,002	82,003 - 98,400
10	0 - 53,740	53,741 - 71,654	71,655 - 89,569	89,570 - 107,480
11	0 - 62,100	62,101 - 82,801	82,802 - 103,502	103,503 - 124,200
12	0 - 66,640	66,641 - 88,854	88,855 - 111,069	111,070 - 133,280

APPLICATION FOR SLIDING FEE SCALE ADJUSTMENT
PLEASE BRING VERIFICATION OF INCOME

Please see attached checklist for acceptable forms of verification.



61 Delano Street, Pulaski, New York 13142-1400
 Phone: (315) 298-6569 Fax: (315) 298-7488 TDD: 711
 www.connextcare.org

Please complete items 1-5 and return.

1. NAME: _____
 First Middle Last
 ADDRESS: _____
 Number and Street City State Zip
 TELEPHONE: _____

2. **CURRENT EMPLOYER:** _____
ADDRESS & PHONE #: _____

3. **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, and any other source.....	_____	_____

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

5. **HOUSEHOLD SIZE:**

<i>NAME</i>	<u>RELATIONSHIP</u>	<u>DATE OF BIRTH</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of the applicant _____ Date _____

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FOR OFFICE USE ONLY

Qualifies for: ____ % Discount ____ Ineligible
 Date of determination: _____ Signature: _____