

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 - 12,760	12,761 - 17,014	17,015 - 21,269	21,270 - 25,520
2	0 - 17,240	17,241 - 22,988	22,989 - 28,735	28,736 - 34,480
3	0 - 21,720	21,721 - 28,961	28,962 - 36,202	36,203 - 43,440
4	0 - 26,200	26,201 - 34,934	34,935 - 43,669	43,670 - 52,400
5	0 - 30,680	30,681 - 40,908	40,909 - 51,135	51,136 - 61,360
6	0 - 35,160	35,161 - 46,881	46,882 - 58,602	58,603 - 70,320
7	0 - 39,640	39,641 - 52,854	52,855 - 66,069	66,070 - 79,280
8	0 - 44,120	44,121 - 58,828	58,829 - 73,535	73,536 - 88,240
9	0 - 48,600	48,601 - 64,801	64,802 - 81,002	81,003 - 97,200
10	0 - 53,080	53,081 - 70,774	70,775 - 88,469	88,470 - 106,160
11	0 - 57,560	57,561 - 76,748	76,749 - 95,935	95,936 - 115,120
12	0 - 62,040	62,041 - 82,721	82,722 - 103,402	103,403 - 124,080

APPLICATION FOR SLIDING FEE SCALE ADJUSTMENT
PLEASE BRING VERIFICATION OF INCOME

Please see attached checklist for acceptable forms of verification.

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: _____