ConnextCare™
A Community of Care

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

SLIDING FEE SCALE PROGRAM

ConnextCare 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 ConnextCare 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 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 - 14,580	14,581 - 19,441	19,442 - 24,302	24,303 - 29,160
2	0 - 19,720	19,721 - 26,294	26,295 - 32,869	32,870 - 39,440
3	0 - 24,860	24,861 - 33,148	33,149 - 41,435	41,436 - 49,720
4	0 - 30,000	30,001 - 40,001	40,002 - 50,002	50,003 - 60,000
5	0 - 35,140	35,141 - 46,854	46,855 - 58,569	58,570 - 70,280
6	0 - 40,280	40,281 - 53,708	53,709 - 67,135	67,136 - 80,560
7	0 - 45,420	45,421 - 60,561	60,562 - 75,702	75,703 - 90,840
8	0 - 50,560	50,561 - 67,414	67,415 - 84,269	84,270 - 101,120
9	0 - 60,840	60,841 - 81,121	81,122 - 101,402	101,403 - 121,680
10	0 - 65,980	65,981 - 87,974	87,975 - 109,969	109,970 - 131,960
11	0 - 71,120	71,121 - 94,828	94,829 - 118,535	118,536 - 142,240
12	0 - 76,260	76,261 - 101,681	101,682 - 127,102	127,103 - 152,520

APPLICATION FOR SLIDING FEE SCALE ADJUSTMENT
*****PLEASE BRING VERIFICATION OF INCOME*****

Please see attached checklist for acceptable forms of verification.

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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**:

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

Signature of the applicant _____Date _____

……

FOR OFFICE USE ONLY

Qualifies for: _____% Discount _____ Ineligible

Date of determination: _____ Signature: _____