SUNRISE CLINICS
SLIDING FEE DISCOUNT PROGRAM APPLICATION

Applicants Name _____ Today's Date _____

Address _____City _____ State ____ Zip_____

It is policy of Sunrise Clinics to provide primary health care services to patients in need regardless of their ability to pay. Discounts are offered to members of households with combined income of 200% and below of the Federal Poverty Level. To determine the percentage for which you qualify we've provided below, a helpful guide for you to look at to see if you qualify. We are anxious to offer reduced co-pays if you qualify.

Sunrise Clinics
Medical and Mental Health
Effective January 27, 2022

# in family	At or below 100% A		101% - 125% B		126% - 150% C		151% - 175% D		176% - 200% E		Over 200% F
(Collect Today)	Nominal Fee of $10		$12		$15		$17		$20		100% Pay
	From	To	From	To	From	To	From	To	From	To	Equal to or Greater Than
1	$0.00	$ 13,590	$ 13,591	$ 16,988	$ 16,989	$ 20,385	$ 20,386	$ 23,783	$ 23,784	$ 27,180	$ 27,181
2	$0.00	$ 18,310	$ 18,311	$ 22,888	$ 22,889	$ 27,465	$ 27,466	$ 32,043	$ 32,044	$ 36,620	$ 36,621
3	$0.00	$ 23,030	$ 23,031	$ 28,788	$ 28,789	$ 34,545	$ 34,546	$ 40,303	$ 40,304	$ 46,060	$ 46,061
4	$0.00	$ 27,750	$ 27,751	$ 34,688	$ 34,689	$ 41,625	$ 41,626	$ 48,563	$ 48,564	$ 55,500	$ 55,501
5	$0.00	$ 32,470	$ 32,471	$ 40,588	$ 40,589	$ 48,705	$ 48,706	$ 56,823	$ 56,824	$ 64,940	$ 64,941
6	$0.00	$ 37,190	$ 37,191	$ 46,488	$ 46,489	$ 55,785	$ 55,786	$ 65,083	$ 65,084	$ 74,380	$ 74,381
7	$0.00	$ 41,910	$ 41,911	$ 52,388	$ 52,389	$ 62,865	$ 62,866	$ 73,343	$ 73,344	$ 83,820	$ 83,821
8	$0.00	$ 46,630	$ 46,631	$ 58,288	$ 58,289	$ 69,945	$ 69,946	$ 81,603	$ 81,604	$ 93,260	$ 93,261
For each additional person	$4,720		$5,900		$7,080		$8,260		$9,440		$9,440

Based on 2022 Federal Poverty Guidelines for Family Size and Income
To participate in this program, patients must provide current proof of income at time of service and upon request.
If patients do not have proof of income at time of service, it must be provided within 30 days or patient will be billed for full amount of service fees

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ACCEPTANCE OF SLIDING FEE DISCOUNT

☐ **YES** I would request to be considered for the Sliding Fee Discount. I will complete the Assessment Form & provide proof of income today, or within 30 days of service.

_____ _____ _____

Patient Name (Please Print) Signature of Patient or Guarantor Date

WAIVER OF SLIDING FEE DISCOUNT – do not sign below if you wish to be considered for a Sliding Fee Discount

☐ **NO** I choose not to complete the Sliding Fee Application at this time. I am waiving my right to any discount for which I may otherwise be entitled. I understand that I will be responsible for full payment of all charges at the time of service.

_____ _____ _____

Patient Name (Please Print) Signature of Patient or Guarantor Date

FAMILY (Helping you calculate how many family members in your family):

Relationship	Include	Do Not Include	Number
Yourself			1
Your spouse	Include if you are legally married, regardless of sex. Include if you are legally married but living apart (for example, spouse is away on military duty, away on work, or away for some reason other than legally separated or divorced).	Do not include if you are legally separated or divorced. You do not need to claim your spouse if you are a victim of domestic abuse, domestic violence, or spousal abandonment.	
Child(ren)	Include number of tax dependent children. Include adopted and foster children, living with you that you can claim as a tax dependent. Include the number of children with whom you share custody if you can claim them as a tax dependent.	Do not include if a child is a non-dependent. Do not include if a child is unborn.	
Other dependents:	Include the number of parents you claim as tax dependents. Include the number of siblings and others who you claim as dependents.	Do not include unmarried domestic partner unless you have a child together or you will claim them as a tax dependent. Do not include roommates.	
TOTAL NUMBER OF PEOPLE SUPPORTED BY THE FAMILY INCOME ABOVE:			

List all household members below:

	Name:	Date of Birth		Name:	Date of Birth
1.	_____	_____	5.	_____	_____
2.	_____	_____	6.	_____	_____
3.	_____	_____	7.	_____	_____
4.	_____	_____	8.	_____	_____

INCOME:

Income	Verification	Amount
Wages, salaries, tips, etc.	Two (2) recent pay stubs. Most recent Form 1040 Line 22 Most recent W2 Box 1 Most recent form 1099 (for self-employment, significant business expenses should be reported on a form 1040 Schedule C) Payroll & Earnings Verification Statement	
Alimony	Most recent month's check stubs	
Unemployment Compensation	Most recent month's check stub or itemized verification letter.	
Social Security Benefits	Most recent month's check stub or itemized verification letter.	
IRA or retirement plan distributions	Most recent month's check stub	
Interest, dividends, rental income	Most recent form 1040	
Bank Account Statement showing deposits from the most recent month Business income	Most recent form 1040	
Capital gains	Most recent form 1040	
Self Declaration of Income (Migrant or Season workers only) Other	Attached form or indicate verbally for recording	
	TOTAL FAMILY ANNUAL INCOME $	

Supporting documentation is required before Sliding Fee Scale Discount can be approved and approved discounts will be valid for twelve (12) months.

Certification:

I certify the following:

1. That my family size and income information listed are accurate.

2. I understand that I am required to provide documentation to verify my family's financial position before my discount can be approved. I agree to provide this information within thirty (30) calendar days of the date on this form.

3. I agree to update my application if my financial situation changes.

4. I will complete a new application each calendar year and no later than twelve (12) months from the date on this form.

5. Sunrise Clinics has provided me with information about the program and I agree to abide by the terms of the Sliding Fee Discount Program (SLDP).

6. I understand that the SLDP applies only to services provided by Sunrise Clinics and that services provided outside of Sunrise Clinics are not covered by the Sunrise Clinics SLDP. Examples of services not covered include, but are not limited to:
    a. Reference laboratory testing
    b. Drugs
    c. X-ray interpretation by a consulting radiologist

7. I understand that if I qualify for the sliding fee discount program, I will pay the lesser of the sliding fee discount or my insurance requirement for each of my appointments.

8. If an unpaid balance exists on my account, I will make payment arrangements and honor the terms of that arrangement. If I am unable to make a payment according to the terms, I will contact the Billing Office at 725-502-2265 before the due date of the payment to discuss my need to modify the payment arrangements.

9. If I am unable to make a payment, I will contact the Billing Office at 725-502-2265

Patient Name (Please Print)	Signature of Patient or Guarantor	Date

FOR OFFICE USE ONLY:

ANNUAL GROSS INCOME CALCULATOR: Income received (frequency):	PER PAY PERIOD	GROSS ANNUAL INCOME
A. Weekly (each week):	$_____x 52 =	$_____
B. Bi-Weekly (every two weeks):	$_____x 26 =	$_____
C. Semi-Monthly (twice a month):	$_____x 24 =	$_____
D. Monthly (each month):	$_____x 12 =	$_____

SUNRISE CLINICS FRONT OFFICE (PATIENT CARE COORDINATOR)

Documentation of Earnings Provided by the Patient: _____ _____
Date Name of Sunrise Employee

SUNRISE CLINICS BILLING OFFICE:

Application ____ Approved _____ _____
Date Name of Sunrise Employee

____ Incomplete

SUNRISE CLINICS FRONT OFFICE:

Patient to be notified by Sunrise Clinics Front Office using Phone or Email