There is Help Available to Pay for your Health Care:

The Community Health Net's Sliding Fee Discount Program

Family Size	Discount A $25.00* *nominal fee		Discount B $35.00		Discount C $45.00		Discount D $55.00		Full Fee 100%
	From	To	From	To	From	To	From	To	
1 Person									
Annually	$0	$12,760	$12,761	$17,098.40	$17,098.41	$21,309.20	$21,309.21	$25,520	$25,521
Weekly	$0	$245	$246	$329	$330	$410	$411	$491	$492
2 Person									
Annually	$0	$17,240	$17,241	$23,101.60	$23,101.61	$28,790.80	$28,790.81	$34,480	$34,481
Weekly	$0	$332	$333	$444	$445	$554	$555	$663	$664
3 Person									
Annually	$0	$21,720	$21,721	$29,104.80	$29,104.81	$36,272.40	$36,272.41	$43,440	$43,441
Weekly	$0	$418	$419	$560	$561	$698	$699	$835	$836
4 Person									
Annually	$0	$26,200	$26,201	$35,108.00	$35,108.01	$43,754.00	$43,754.01	$52,400	$52,401
Weekly	$0	$504	$505	$675	$676	$841	$842	$1,008	$1,009
5 Person									
Annually	$0	$30,680	$30,681	$41,111.20	$41,111.21	$51,235.60	$51,235.61	$61,360	$61,361
Weekly	$0	$590	$591	$791	$792	$985	$986	$1,180	$1,181
6 Person									
Annually	$0	$35,160	$35,161	$47,114.40	$47,114.41	$58,717.20	$58,717.21	$70,320	$70,321
Weekly	$0	$676	$677	$906	$907	$1,129	$1,130	$1,352	$1,353
7 Person									
Annually	$0	$39,640	$39,641	$53,117.60	$53,117.61	$66,198.80	$66,198.81	$79,280	$79,281
Weekly	$0	$762	$763	$1,021	$1,022	$1,273	$1,274	$1,525	$1,526
8 Person									
Annually	$0	$44,120	$44,121	$59,120.80	$59,120.81	$73,680.40	$73,680.41	$88,240	$88,241
Weekly	$0	$848	$849	$1,137	$1,138	$1,417	$1,418	$1,697	$1,698

Community Health Net is a Federally Qualified Health Center (FQHC)

As a FQHC, we are able to offer a discount on services based on income and family size. We use the above table to determine your discount eligibility.
(This table can be located at https://aspe.hhs.gov/poverty-guidelines)

What services are included in the program?

- Primary care visits at Community Health Net
- Behavioral health visits at Community Health Net
- Eye clinic visits at Community Health Net
- Dental care visits at Community Health Net
- CHN Pharmacy (see Pharmacy for eligible items)

What kinds of services are NOT included in the program?

- Hospital Visits, Hospital Services, Nursing Homes
- Imaging facilities (x-rays, CT, MRI, etc.)
- Laboratories (ACL, etc.)
- Some dental procedures: partials, dentures, crowns, or items produced at an offsite lab

Call Today
to learn more!

814-455-7222
or
814-454-4530 x287

Sliding Fee Discounts are determined by using:

- Federal Income Tax forms
- W-2's
- Consecutive Pay stubs
- Unemployment Benefits
- Social Security Benefits
- Self-declaration options are also available

Recertification is required annually or when changes to family size or income occur. Once you have been approved for the Sliding Fee Discount Program, you will remain active in the program for **one year**.

v.1.2020

COMMUNITY Health Net
Everyday people Extraordinary care

Sliding Fee Discount Program Application

It is the policy of Community Health Net to provide services regardless of the patient's ability to pay. As a Federally Qualified Health Center, Community Health Net offers a Sliding Fee Discount Program designed to allow patients to pay for healthcare services based on family size and income; therefore, patients earning less money will pay less than those that earn more. The discount will apply to services received at all Community Health Net locations. Some exclusions apply.

To apply for the Sliding Fee Discount Program, please complete the following information and return to the front desk with proof of household income and photo identification. To remain eligible for the discount, this form must be completed every 12 months or if your family/ financial situation changes.

Applicant Name: _____

Current Address: _____

Email Address: _____

Phone Number: _____Alternate Phone Number: _____

Please list the names of all household members			Date of Birth
First	M	Last	MM/DD/YYYY

I, _____ (print name), certify that the information provided is correct to the best of my knowledge. I agree to notify Community Health Net if there are any changes in my household size or income. I am aware that this information is reviewed based on the Federal Poverty Guidelines published annually by the Federal Government.
I understand that I must requalify annually to maintain eligibility.

X_____
Signature of Applicant or Responsible Party Date

TO BE COMPLETED BY COMMUNITY HEALTH NET STAFF

Household Size: _____ Annual Income: $_____ Person Number: _____
OR
Refused to Complete: ____ Income Verified: ____ Photo ID Copied: ____ Account Number: _____

Verified By: _____ Discount (circle one)

Effective Date: _____ Expiration Date: _____ A B C D DNQ