Lorain County Health & Dentistry

How to apply for the Sliding Fee Discount Program (SFDP)

1. Call (440) 240-1655 to make an appointment with a Billing Associate
   Para asistencia en Español llamar 440-240-1655.
2. Bring the following documents to your SFDP appointment
   a. Photo ID
   b. Proof of income for everyone in your household
3. **Who is included in the household**
   Do Include:
   - Yourself
   - Your Spouse
   - Your children under 19 who live with you and their children who also live with you (if employed please provide their proof of income)
   - Your unmarried partner IF you have a common child together that resides in the household
   - Anyone else under 19 that lives with you if you are their legal guardian and have proper documentation
   - Your children 19-26 who live with you and are full time students (living at the school campus is considered "living with you") (provide documentation of school enrollment)

   Do NOT Include
   - Your unmarried partner if you do not have children together
   - Your unmarried partner's children
   - Your parents who live with you
   - Other relatives who live with you unless legal guardian (provide documentation)

- **What income is to be included**
  1. Everyone in the household's income is counted
  2. All earned income (paystubs, W2's, current tax form, under the table income)
  3. All other income – Child support/alimony, Interest/Rental Income, Self-Employed income, strike benefits, unemployment compensation, pension, retirement, railroad benefits, social security, disability, public assistance.
  4. If there is no income in the household then a letter must be written stating who is supporting the patient.

Lorain County Health & Dentistry Sliding Fee Discount Program - 2022 Federal Poverty Guidelines - effective 1/12/2022

Level 1

Family Income up to to and including 100% of Federal Poverty Guidelines

Family Size-# of Persons in Family	Income Minimum	Income Maximum	(1) Nominal Charge for Medical, Vision & Initial Beh. Health Visit, except for (4) & (5)	(2) Nominal Charge for Follow-up Beh Health visits	(3) Nominal Charge for Dental Services, except for (6), (7), (8), (9), (10,) & (11)	(4) Nominal Charge for Insertion of Mirena or Kyleena IUD Medical Visit- Includes Supplies and Services	(5) Nominal Charge for Insertion of Nexplanon Visit- Includes Supplies and Services	(6) Nominal Charge for Root Canal: Anterior	(7) Nominal Charge for Root Canal: Posterior/Pre-Molars	(8) Nominal Charge for Root Canal: Posterior Molars	(9) Nominal Charge for Crown: Porcelain- Includes Supplies and Services	(10) Nominal Charge for Crown: Stainless Steel- Includes Supplies and Services	(11) Nominal Charge for a Dental Bridge- Includes Supplies and Services
1	$0	$13,590	$20	$5	$35	$270	$420	$250	$300	$350	$430	$352	$430 per unit (tooth)
2	$0	$18,310											
3	$0	$23,030											
4	$0	$27,750											
5	$0	$32,470											
6	$0	$37,190											
7	$0	$41,910											
8	$0	$46,630											
9	$0	$51,350											
10	$0	$56,070											
11	$0	$60,790											
12	$0	$65,510											

Level 2

Family Income 101 - 120% of Federal Poverty Guidelines

Family Size-# of Persons in Family	Income Minimum	Income Maximum	(1) Discounted Fee for Medical, Vision & Initial Beh. Health Visit, except for (4) & (5)	(2) Discounted Fee for Follow-up Beh Health visits	(3) Dicounted Fee for Dental Services, except for (6), (7), (8), (9), (10,) & (11)	(4) Discounted Fee for Insertion of Mirena or Kyleena IUD Medical Visit - Includes Supplies and Services	(5) Discounted Fee for Insertion of Nexplanon Medical Visit - Includes Supplies and Services	(6) Discounted Fee for Root Canal: Anterior	(7) Discounted Fee for Root Canal: Posterior/Pre-Molars	(8) Discounted Fee for Root Canal: Posterior Molars	(9) Discounted Fee for Crown: Porcelain - Includes Supplies and Services	(10) Discounted Fee for Crown: Stainless Steel - Includes Supplies and Services	(11) Discounted Fee for a Dental Bridge - Includes Supplies and Services
1	$13,591	$16,308	$30	$6	The greater of 10% of the fees or $36	$280	$430	$255	$305	$355	$435	$357	$435 per unit (tooth)
2	$18,311	$21,972											
3	$23,031	$27,636											
4	$27,751	$33,300											
5	$32,471	$38,964											
6	$37,191	$44,628											
7	$41,911	$50,292											
8	$46,631	$55,956											
9	$51,351	$61,620											
10	$56,071	$67,284											
11	$60,791	$72,948											
12	$65,511	$78,612											

Level 3

Family Income 121 - 140% of Federal Poverty Guidelines

Family Size-# of Persons in Family	Income Minimum	Income Maximum	(1) Discounted Fee for Medical, Vision & Initial Beh. Health Visit, except for (4) & (5)	(2) Discounted Fee for Follow-up Beh Health visits	(3) Dicounted Fee for Dental Services, except for (6), (7), (8), (9), (10,) & (11)	(4) Discounted Fee for Insertion of Mirena or Kyleena IUD Medical Visit - Includes Supplies and Services	(5) Discounted Fee for Insertion of Nexplanon Medical Visit - Includes Supplies and Services	(6) Discounted Fee for Root Canal: Anterior	(7) Discounted Fee for Root Canal: Posterior/Pre-Molars	(8) Discounted Fee for Root Canal: Posterior Molars	(9) Discounted Fee for Crown: Porcelain - Includes Supplies and Services	(10) Discounted Fee for Crown: Stainless Steel - Includes Supplies and Services	(11) Discounted Fee for a Dental Bridge - Includes Supplies and Services
1	$16,309	$19,026	$40	$7	The greater of 20% of the fees or $37	$290	$440	$260	$310	$360	$440	$362	$440 per unit (tooth)
2	$21,973	$25,634											
3	$27,637	$32,242											
4	$33,301	$38,850											
5	$38,965	$45,458											
6	$44,629	$52,066											
7	$50,293	$58,674											
8	$55,957	$65,282											
9	$61,621	$71,890											
10	$67,285	$78,498											
11	$72,949	$85,106											
12	$78,613	$91,714											

Level 4

Family Income 141 - 160% of Federal Poverty Guidelines

Family Size-# of Persons in Family	Income Minimum	Income Maximum	(1) Discounted Fee for Medical, Vision & Initial Beh. Health Visit, except for (4) & (5)	(2) Discounted Fee for Follow-up Beh Health visits	(3) Dicounted Fee for Dental Services, except for (6), (7), (8), (9), (10,) & (11)	(4) Discounted Fee for Insertion of Mirena or Kyleena IUD Medical Visit - Includes Supplies and Services	(5) Discounted Fee for Insertion of Nexplanon Medical Visit - Includes Supplies and Services	(6) Discounted Fee for Root Canal: Anterior	(7) Discounted Fee for Root Canal: Posterior/Pre-Molars	(8) Discounted Fee for Root Canal: Posterior Molars	(9) Discounted Fee for Crown: Porcelain - Includes Supplies and Services	(10) Discounted Fee for Crown: Stainless Steel - Includes Supplies and Services	(11) Discounted Fee for a Dental Bridge - Includes Supplies and Services
1	$19,027	$21,744	$50	$8	The greater of 40% of the fees or $38	$300	$450	$265	$315	$365	$445	$367	$445 per unit (tooth)
2	$25,635	$29,296											
3	$32,243	$36,848											
4	$38,851	$44,400											
5	$45,459	$51,952											
6	$52,067	$59,504											
7	$58,675	$67,056											
8	$65,283	$74,608											
9	$71,891	$82,160											
10	$78,499	$89,712											
11	$85,107	$97,264											
12	$91,715	$104,816											

Level 5

Family Income 161 - 180% of Federal Poverty Guidelines

Family Size-# of Persons in Family	Income Minimum	Income Maximum	(1) Discounted Fee for Medical, Vision & Initial Beh. Health Visit, except for (4) & (5)	(2) Discounted Fee for Follow-up Beh Health visits	(3) Dicounted Fee for Dental Services, except for (6), (7), (8), (9), (10,) & (11)	(4) Discounted Fee for Insertion of Mirena or Kyleena IUD Medical Visit - Includes Supplies and Services	(5) Discounted Fee for Insertion of Nexplanon Medical Visit - Includes Supplies and Services	(6) Discounted Fee for Root Canal: Anterior	(7) Discounted Fee for Root Canal: Posterior/Pre-Molars	(8) Discounted Fee for Root Canal: Posterior Molars	(9) Discounted Fee for Crown: Porcelain - Includes Supplies and Services	(10) Discounted Fee for Crown: Stainless Steel - Includes Supplies and Services	(11) Discounted Fee for a Dental Bridge - Includes Supplies and Services
1	$21,745	$24,462	$60	$9	The greater of 60% of the fees or $39	$310	$460	$280	$320	$370	$450	$372	$450 per unit (tooth)
2	$29,297	$32,958											
3	$36,849	$41,454											
4	$44,401	$49,950											
5	$51,953	$58,446											
6	$59,505	$66,942											
7	$67,057	$75,438											
8	$74,609	$83,934											
9	$82,161	$92,430											
10	$89,713	$100,926											
11	$97,265	$109,422											
12	$104,817	$117,918											

Level 6

Family Income 181 - 200% of Federal Poverty Guidelines

Family Size-# of Persons in Family	Income Minimum	Income Maximum	(1) Discounted Fee for Medical, Vision & Initial Beh. Health Visit, except for (4) & (5)	(2) Discounted Fee for Follow-up Beh Health visits	(3) Dicounted Fee for Dental Services, except for (6), (7), (8), (9), (10,) & (11)	(4) Discounted Fee for Insertion of Mirena or Kyleena IUD Medical Visit - Includes Supplies and Services	(5) Discounted Fee for Insertion of Nexplanon Medical Visit - Includes Supplies and Services	(6) Discounted Fee for Root Canal: Anterior	(7) Discounted Fee for Root Canal: Posterior/Pre-Molars	(8) Discounted Fee for Root Canal: Posterior Molars	(9) Discounted Fee for Crown: Porcelain - Includes Supplies and Services	(10) Discounted Fee for Crown: Stainless Steel - Includes Supplies and Services	(11) Discounted Fee for a Dental Bridge - Includes Supplies and Services
1	$24,463	$27,180	$70	$10	The greater of 80% of the fees or $40	$320	$470	$285	$325	$375	$455	$377	$455 per unit (tooth)
2	$32,959	$36,620											
3	$41,455	$46,060											
4	$49,951	$55,500											
5	$58,447	$64,940											
6	$66,943	$74,380											
7	$75,439	$83,820											
8	$83,935	$93,260											
9	$92,431	$102,700											
10	$100,927	$112,140											
11	$109,423	$121,580											
12	$117,919	$131,020											

For families with more than 12 persons, add $4,720 for each additional person.

No patient will be denied services due to inability to pay

In the event you are unable to pay your account balance, please ask to speak with a Billing Associate about your options

Please ask to speak with a Financial and Enrollment Assistant for more information on the Lorain County Health & Dentistry Sliding Fee Discount Program

LCH&D patients who are eligible for the sliding fee discounts and have third-party coverage will be charged no more for any out-of-pocket costs, i.e. copays, deductibles, than the amount they would pay under the applicable SFDS discount pay class level above.

For more information, please visit our website at www.lorainhealth-dentistry.org

Lorain County Health & Dentistry

Lorain County Health & Dentistry Programa de Descuento con Cobros en Escala - 2022 Nivel de Pobreza – efectivo 01/12/2022

Nivel 1

Ingresos familiares hasta e incluyendo el 100% de las pautas de pobreza

Tamaño familiar # de personas en la familia	Ingreso Mínimo	Ingreso Máximo	(1) Cargo nominal por concepto médico, de la vista y de Beh inicial. Visita de salud, excepto para (4) & (5)	(2) Cargo nominal por visitas de seguimiento de Beh Health	(3) Cargo nominal por servicios dentales, excepto para (6), (7), (8), (9), (10,) & (11)	(4) Cargo nominal por visita médica con DIU Mirena o Kyleena - Incluye suministros y servicios	(5) Cargo nominal por visita a Nexplanon - Incluye suministros y servicios	(6) Carga nominal por conducto radicular: Anterior	(7) Carga nominal del conducto radicular: posterior / premolares	(8) Carga nominal del conducto radicular: molares posteriores	(9) Cargo nominal por corona: porcelana - Incluye suministros y servicios	(10) Cargo nominal por corona: acero inoxidable - Incluye suministros y servicios	(11) Cargo nominal por un puente dental - Incluye suministros y servicios
1	$0	$13,590	$20	$5	$35	$270	$420	$250	$300	$350	$430	$352	$430 per unit (tooth)
2	$0	$18,310											
3	$0	$23,030											
4	$0	$27,750											
5	$0	$32,470											
6	$0	$37,190											
7	$0	$41,910											
8	$0	$46,630											
9	$0	$51,350											
10	$0	$56,070											
11	$0	$60,790											
12	$0	$65,510											

Nivel 2

Ingreso familiar 101 - 120% de las pautas de pobreza

Tamaño familiar # de personas en la familia	Ingreso Mínimo	Ingreso Máximo	(1) Tarifa con descuento para gastos médicos, de visión e iniciales Beh. Visita de salud, excepto para (4) & (5)	(2) Tarifa con descuento para visitas de seguimiento de Beh Health	(3) Tarifa con descuento por servicios dentales, excepto (6), (7), (8), (9), (10,) & (11)	(4) Tarifa con descuento para visita médica con DIU Mirena o Kyleena - Incluye suministros y servicios	(5) Tarifa con descuento por visita a Nexplanon - Incluye suministros y servicios	(6) Tarifa con descuento para conducto radicular: anterior	(7) Tarifa con descuento para conducto radicular: posterior / premolares	(8) Tarifa con descuento por conducto radicular: molares posteriores	(9) Tarifa con descuento para corona: porcelana - Incluye suministros y servicios	(10) Tarifa con descuento por corona: acero inoxidable - Incluye suministros y servicios	(11) Tarifa con descuento para un puente dental - Incluye suministros y servicios
1	$13,591	$16,308	$30	$6	The greater of 10% of the fees or $36	$280	$430	$255	$305	$355	$435	$357	$435 per unit (tooth)
2	$18,311	$21,972											
3	$23,031	$27,636											
4	$27,751	$33,300											
5	$32,471	$38,964											
6	$37,191	$44,628											
7	$41,911	$50,292											
8	$46,631	$55,956											
9	$51,351	$61,620											
10	$56,071	$67,284											
11	$60,791	$72,948											
12	$65,511	$78,612											

Nivel 3

Ingreso familiar 121 - 140% de las pautas de pobreza

Tamaño familiar # de personas en la familia	Ingreso Mínimo	Ingreso Máximo	(1) Tarifa con descuento para gastos médicos, de visión e iniciales Beh. Visita de salud, excepto para (4) & (5)	(2) Tarifa con descuento para visitas de seguimiento de Beh Health	(3) Tarifa con descuento por servicios dentales, excepto (6), (7), (8), (9), (10,) & (11)	(4) Tarifa con descuento para visita médica con DIU Mirena o Kyleena	(4) Tarifa con descuento para visita médica con DIU Mirena o Kyleena - Incluye suministros y servicios	(5) Tarifa con descuento por visita a Nexplanon - Incluye suministros y servicios	(6) Tarifa con descuento para conducto radicular: anterior	(7) Tarifa con descuento para conducto radicular: posterior / premolares	(8) Tarifa con descuento por conducto radicular: molares posteriores	(9) Tarifa con descuento para corona: porcelana - Incluye suministros y servicios	(10) Tarifa con descuento por corona: acero inoxidable - Incluye suministros y servicios	(11) Tarifa con descuento para un puente dental - Incluye suministros y servicios
1	$16,309	$19,026	$40	$7	The greater of 20% of the fees or $37	$290	$440	$260	$310	$360	$440	$362	$440 per unit (tooth)
2	$21,973	$25,634											
3	$27,637	$32,242											
4	$33,301	$38,850											
5	$38,965	$45,458											
6	$44,629	$52,066											
7	$50,293	$58,674											
8	$55,957	$65,282											
9	$61,621	$71,890											
10	$67,285	$78,498											
11	$72,949	$85,106											
12	$78,613	$91,714											

Nivel 4

Ingreso familiar 141 - 160% de las pautas de pobreza

Tamaño familiar # de personas en la familia	Ingreso Mínimo	Ingreso Máximo	(1) Tarifa con descuento para gastos médicos, de visión e iniciales Beh. Visita de salud, excepto para (4) & (5)	(2) Tarifa con descuento para visitas de seguimiento de Beh Health	(3) Tarifa con descuento por servicios dentales, excepto (6), (7), (8), (9), (10,) & (11)	(4) Tarifa con descuento para visita médica con DIU Mirena o Kyleena - Incluye suministros y servicios	(5) Tarifa con descuento por visita a Nexplanon - Incluye suministros y servicios	(6) Tarifa con descuento para conducto radicular: anterior	(7) Tarifa con descuento para conducto radicular: posterior / premolares	(8) Tarifa con descuento por conducto radicular: molares posteriores	(9) Tarifa con descuento para corona: porcelana - Incluye suministros y servicios	(10) Tarifa con descuento por corona: acero inoxidable - Incluye suministros y servicios	(11) Tarifa con descuento para un puente dental - Incluye suministros y servicios
1	$19,027	$21,744	$50	$8	The greater of 40% of the fees or $38	$300	$450	$265	$315	$365	$445	$367	$445 per unit (tooth)
2	$25,635	$29,296											
3	$32,243	$36,848											
4	$38,851	$44,400											
5	$45,459	$51,952											
6	$52,067	$59,504											
7	$58,675	$67,056											
8	$65,283	$74,608											
9	$71,891	$82,160											
10	$78,499	$89,712											
11	$85,107	$97,264											
12	$91,715	$104,816											

Nivel 5

Ingreso familiar 161 - 180% de las pautas de pobreza

Tamaño familiar # de personas en la familia	Ingreso Mínimo	Ingreso Máximo	(1) Tarifa con descuento para gastos médicos, de visión e iniciales Beh. Visita de salud, excepto para (4) & (5)	(2) Tarifa con descuento para visitas de seguimiento de Beh Health	(3) Tarifa con descuento por servicios dentales, excepto (6), (7), (8), (9), (10,) & (11)	(4) Tarifa con descuento para visita médica con DIU Mirena o Kyleena - Incluye suministros y servicios	(5) Tarifa con descuento por visita a Nexplanon - Incluye suministros y servicios	(6) Tarifa con descuento para conducto radicular: anterior	(7) Tarifa con descuento para conducto radicular: posterior / premolares	(8) Tarifa con descuento por conducto radicular: molares posteriores	(9) Tarifa con descuento para corona: porcelana - Incluye suministros y servicios	(10) Tarifa con descuento por corona: acero inoxidable - Incluye suministros y servicios	(11) Tarifa con descuento para un puente dental - Incluye suministros y servicios
1	$21,746	$24,462	$60	$9	The greater of 60% of the fees or $39	$310	$460	$280	$320	$370	$450	$372	$450 per unit (tooth)
2	$29,298	$32,958											
3	$36,850	$41,454											
4	$44,402	$49,950											
5	$51,954	$58,446											
6	$59,506	$66,942											
7	$67,058	$75,438											
8	$74,610	$83,934											
9	$82,162	$92,430											
10	$89,714	$100,926											
11	$97,266	$109,422											
12	$104,818	$117,918											

Nivel 6

Ingreso familiar 181 - 200% de las pautas de pobreza

Tamaño familiar # de personas en la familia	Ingreso Mínimo	Ingreso Máximo	(1) Tarifa con descuento para gastos médicos, de visión e iniciales Beh. Visita de salud, excepto para (4) & (5)	(2) Tarifa con descuento para visitas de seguimiento de Beh Health	(3) Tarifa con descuento por servicios dentales, excepto (6), (7), (8), (9), (10,) & (11)	(4) Tarifa con descuento para visita médica con DIU Mirena o Kyleena - Incluye suministros y servicios	(5) Tarifa con descuento por visita a Nexplanon - Incluye suministros y servicios	(6) Tarifa con descuento para conducto radicular: anterior	(7) Tarifa con descuento para conducto radicular: posterior / premolares	(8) Tarifa con descuento por conducto radicular: molares posteriores	(9) Tarifa con descuento para corona: porcelana - Incluye suministros y servicios	(10) Tarifa con descuento por corona: acero inoxidable - Incluye suministros y servicios	(11) Tarifa con descuento para un puente dental - Incluye suministros y servicios
1	$24,463	$27,180	$70	$10	The greater of 80% of the fees or $40	$320	$470	$285	$325	$375	$455	$377	$455 per unit (tooth)
2	$32,959	$36,620											
3	$41,455	$46,060											
4	$49,951	$55,500											
5	$58,447	$64,940											
6	$66,943	$74,380											
7	$75,439	$83,820											
8	$83,935	$93,260											
9	$92,431	$102,700											
10	$100,927	$112,140											
11	$109,423	$121,580											
12	$117,919	$131,020											

Para familias con más de 12 personas, agregue $ 4,720 por cada persona adicional.

A ningún paciente se le negarán los servicios por no poder pagar

En caso de que no pueda pagar el saldo de su cuenta, solicite hablar con un asociado de facturación sobre sus opciones.

Solicite hablar con un asistente financiero y de inscripción para obtener más información sobre el programa de descuento de tarifa variable de salud y odontología del condado de Lorain.

A los pacientes de LCH & D que son elegibles para los descuentos de tarifa variable y tienen cobertura de terceros no se les cobrará más por los costos de bolsillo, es decir, copagos, deducibles, que la cantidad que pagarían según el nivel de clase de pago de descuento de SFDS aplicable anterior .

Para obtener más información, visite nuestro sitio web en www.lorainhealth-dentistry.org

Lorain County Health & Dentistry

Sliding Fee Discount Program Application

The sliding fee discount program provides reduced charges to patients who qualify. This application is good for 12 months from the date signed unless noted below. You must reapply upon expiration, typically 12 months, but can be earlier as noted below. Circumstances that may affect your discount include divorce, death of spouse, leave of absence from work, dependent turning 19 who is not a full-time student. Additional verification may be required.

List the names of all persons indicated below, starting with yourself, even if they already have insurance:

Do Include:

- Yourself * Your Spouse
- Your children under 19 who live with you and their children who also live with you (if employed please provide their proof of income)
- Your unmarried partner IF you have a common child together that resides in the household
- Anyone else under 19 that lives with you if you are their legal guardian and have proper documentation
- Your children 19-26 who live with you and are full time students (living at the school campus is considered "living with you") (provide documentation of school enrollment)

Do NOT Include

- Your unmarried partner if you do not have children together
- Your unmarried partner's children * Your parents who live with you
- Other relatives who live with you unless legal guardian (provide documentation)

SFS Eligible	Full Name	Social Security # *(optional)*	Date of Birth	Relationship	Employer
Y N					
Y N					
Y N					
Y N					
Y N					

Income includes *all income* for the *entire household* listed above. Please check appropriate box(es) of verification and attach a copy of the item to be verified.

- ❑ Federal Income Tax Return
- ❑ Employee W2s
- ❑ Child Support/Alimony
- ❑ Interest, Rental Income
- ❑ Other (self-employment income)
- ❑ Pay Stubs ❑ Weekly ❑ Bi-weekly
- ❑ Strike Benefits / Unemployment Comp
- ❑ Pension/Retirement/Railroad Benefits
- ❑ Social Security / Disability / Public Assistance
- ❑ I did not work or have any income

I have completed this application for discounted care and confirm that all information (including any self-attestations) provided is truthful to the best of my knowledge. I understand that I may be eligible, based on the proof I provided, for discounted care. I also understand that if I am eligible for a discount, I will be expected to pay the associated fee at the time of each office visit.

_____ _____ _____

Applicant Signature Phone Number Date

Providing false information on this form may affect your ability to get health care at Lorain County Health & Dentistry

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For Accounting Use Only:

Yearly Gross Income _____

Number of Eligible Household Members? _____

Pending Medicaid? _____

Expires _____

Medical/Vision/ Behavioral Health Nominal Charge/ Discounted Fees

Nominal Charge $20

Level _____ _____

Dental Nominal Charge/ Discounted Fees

Nominal Charge $35

The greater of _____% of the fees or

$36 $37 $38 $39 $40 circle one

Financial Representative _____ Date _____

Lorain County Health & Dentistry

Aplicación Del Programa De Descuento

El programa de descuento de tarifas deslizantes proporciona cargos reducidos a los pacientes que califican. Esta solicitud es buena durante 12 meses a partir de la fecha firmada a menos que se indique a continuación. Debe volver a aplicar al expirar, normalmente 12 meses, pero puede ser anterior como se indica a continuación. Las circunstancias que pueden afectar su descuento incluyen divorcio, muerte del cónyuge, licencia de ausencia del trabajo, dependiente de cumplir 19 años que no es un estudiante de tiempo completo. Es posible que se requiere una verificación adicional.

Enumere los nombres de todas las personas indicadas a continuación, empezando por usted mismo, incluso si ya tienen seguro:

Incluir:

• Usted mismo * Su cónyuge
• Sus hijos menores de 19 años que viven con usted y sus hijos que también viven con usted (si están empleados, por favor proporcionen su comprobante de ingresos)
• Su pareja soltera SI tiene un hijo común juntos que reside en el hogar
• Cualquier otra persona menor de 19 años que viva con usted si usted es su tutor legal y tiene la documentación adecuada
• Sus hijos de 19 a 26 años que viven con usted y son estudiantes de tiempo completo (vivir en el campus escolar se considera "vivir con usted") (proporcionar documentación de la inscripción escolar)

NO incluya

• Su pareja soltera si no tiene hijos juntos
• Los hijos de su pareja soltera * Sus padres que viven con usted
• Otros parientes que viven con usted a menos que tutor legal (proporcionar documentación)

SFS Elegible	Nombre Completo	Seguro Social # (opcional)	Fecha del Nacimiento	Relación	Empleado
Si NO					
Si NO					
SI NO					
SI NO					
Si NO					

Los ingresos incluyen todos los ingresos para todo el hogar mencionado anteriormente. Por favor, marque las casillas apropiadas de verificación y adjunte una copia del artículo que se va a verificar.

☐ Declaración del impuesto federal sobre la renta
☐ Empleado W2s ▸ Beneficios de huelga
☐ Manutención/Pensión infantil
☐ Intereses, Renta de Alquiler
☐Otros (ingresos por autoempleo)
☐ Pagar talones ☐ Semanalmente ☐ Quincenal
☐ Compensación de desempleo
☐ Pensiones/Jubilación/Beneficios ferroviarios
☐ Seguridad Social / Discapacidad / Asistencia Pública
☐ Yo no trabajaba ni tenía ingresos

Yo he completado esta solicitud de atención con descuento y confirmo que toda la información (incluyendo cualquier auto atestación) proporcionada es veraz hasta donde yo sé. Entiendo que puedo ser elegible, basado en la prueba que proporte, para la atención con descuento. También entiendo que, si soy elegible para un descuento, se espera que pague la tarifa asociada en el momento de cada visita a la oficina.

_____ _____ _____

Firma del solicitante **Número de teléfono** **Fecha**

Lorain County Health & Dentistry

Aplicación Del Programa De Descuento

Proporcionar información falsa sobre este formulario puede afectar su capacidad para recibir atención médica en Lorain County Health & Dentistry

Sólo para uso contable:

Ingreso Limpio anual _____ **Médico/Visión/Salud conductual** **Cargo nominal $20**

Cargo nominal/Descuento **Nivel** _____

Número de elegibles
¿Miembros del hogar? _____

¿Pendiente de Medicad? _____ **Carga nominal dental/** **Cargo nominal $35**

Tarifas con descuento **El mayor de** _____**% de las tarifas**

o $36 $37 $38 $39 $40 círculo uno

Expira _____

Representante financiero _____ **Fecha** _____

Los siguientes servicios están disponibles a una tarifa reducida para los pacientes que califican para la escala de tarifas deslizantes.

Servicios Médicos Servicios	Dental Servicios	Visión Salud	Conductual
Oficina visita	visitas a oficina	visita oficina	oficina
Procedimientos	Procedimientos	Procedimientos	
Vacunas			
Inyecciones			

Servicios no cubiertos por la escala de tarifas deslizantes

Servicios hospitalarios

Pruebas de laboratorio

Anteojos y productos relacionados

Se recomienda a los pacientes que presenten una solicitud revisada del programa de descuento de tarifas deslizantes si se produce una de las siguientes condiciones:

Circunstancias	Requiere verificación
Divorcio	Carta del abogado indicando que un divorcio está en proceso
Defunción del obituario de su Esposo	Obituario de periódico o certificado de defunción
Pérdida de empleo	Periodo de espera 90 días con declaración
Permiso de ausencia del trabajo	Waiting period 90 days with a statement form employer.
19 Años	1 mes de cheques de nómina o una declaración de la lista del
(No estudiante de tiempo completo)	empleador

Lorain County Health & Dentistry

The following services are available at a reduced rate for patients who qualify for the Sliding Fee Scale.

Medical Services	**Dental Services**	**Vision Services**	**Behavioral Health**
Office Visits	Office Visits	Office Visits	Office Visits
Procedures	Procedures	Procedures	
Immunizations			
Injections			

Services Not Covered Under the Sliding Fee Scale

Hospital services

Lab tests

Eye Glasses and related products

Patients are encouraged to submit a revised Sliding Fee Discount Program Application if one of the following conditions occurs:

Circumstances	**Verification Required**
Divorce	Letter from attorney stating a divorce is in process.
Death of Spouse	Obituary from newspaper or death certificate.
Loss of job	Waiting period 90 days with statement from Unemployment or employer.
Leave of Absence from Work	Waiting period 90 days with a statement form employer.
19 Year Old (Not Full-Time Student)	1 month of payroll check stubs or a statement from employer listing gross wages.

Lorain County Health & Dentistry

Hardship Appeal for Reduced/Waived Fees

Instructions: Please complete the request for a hardship appeal for reduced/waived fees, which could result in reduced/waived fees. Supporting documentation is required. You will receive notification by letter at the address provided below.

Patient Information

Name: _____

Address: _____

Date of Birth: _____

Phone Number:_____

Please select the type of hardship assistance you are requesting from Lorain County Health & Dentistry:

- ☐ 1x visit at reduced/waived fees. Please indicate amount able to pay $_____.
- ☐ Past due balance forgiveness in the amount of $_____.
- ☐ Other (please describe and include amount requesting to be reduced/waived)

_____

_____

_____

Please select which of the following hardships you are experiencing and provide supporting documentation:

- ☐ Terminal Illness (will be denoted in patient's chart)
- ☐ Unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member
- ☐ File for bankruptcy in past 3 months
- ☐ Other reasons that indicate the patient would be unable to pay medical bills and still be able to pay for other basic necessary expenses and/or expenses for medical necessity
- ☐ Catastrophic situation – death or disability of a family member, flood/fire/other of home, other natural disasters

Additional comments (not required) :

_____

_____

_____

Documentation received by: _____Date_____

Signature: _____ Date:_____

Approved by: _____ Date: _____