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 - 2023 Federal Poverty Guidelines - Effective 10/17/2023

Family Size	Household Income					
	0% - 100%	101% - 120%	121% - 140%	141% - 160%	161% - 180%	181% - 200%
1	$0 - $14,580	$ 14,581 - $ 17,496	$ 17,497 - $ 20,412	$ 20,413 - $ 23,328	$ 23,329 - $ 26,244	$ 26,245 - $ 29,160
2	$0 - $19,720	$ 19,721 - $ 23,664	$ 23,665 - $ 27,608	$ 27,609 - $ 31,552	$ 31,553 - $ 35,496	$ 35,497 - $ 39,440
3	$0 - $24,860	$ 24,861 - $ 29,832	$ 29,833 - $ 34,804	$ 34,805 - $ 39,776	$ 39,777 - $ 44,748	$ 44,749 - $ 49,720
4	$0 - $30,000	$ 30,001 - $ 36,000	$ 36,001 - $ 42,000	$ 42,001 - $ 48,000	$ 48,001 - $ 54,000	$ 54,001 - $ 60,000
5	$0 - $35,140	$ 35,141 - $ 42,168	$ 42,169 - $ 49,196	$ 49,197 - $ 56,224	$ 56,225 - $ 63,252	$ 63,253 - $ 70,280
6	$0 - $40,280	$ 40,281 - $ 48,336	$ 48,337 - $ 56,392	$ 56,393 - $ 64,448	$ 64,449 - $ 72,504	$ 72,505 - $ 80,560
7	$0 - $45,420	$ 45,421 - $ 54,504	$ 54,505 - $ 63,588	$ 63,589 - $ 72,672	$ 72,673 - $ 81,756	$ 81,757 - $ 90,840
8	$0 - $50,560	$ 50,561 - $ 60,672	$ 60,673 - $ 70,784	$ 70,785 - $ 80,896	$ 80,897 - $ 91,008	$ 91,009 - $ 101,120
9	$0 $55,700	$ 55,701 $ 66,840	$ 66,841 $ 77,980	$ 77,981 $ 89,120	$ 89,121 $ 100,260	$ 100,261 $ 111,400
10	$0 $60,840	$ 60,841 $ 73,008	$ 73,009 $ 85,176	$ 85,177 $ 97,344	$ 97,345 $ 109,512	$ 109,513 $ 121,680
11	$0 $65,980	$ 65,981 $ 79,176	$ 79,177 $ 92,372	$ 92,373 $ 105,568	$ 105,569 $ 118,764	$ 118,765 $ 131,960
12	$0 $71,120	$ 71,121 $ 85,344	$ 85,345 $ 99,568	$ 99,569 $ 113,792	$ 113,793 $ 128,016	$ 128,017 $ 142,240
Service	**Patient Cost**					
Medical, Vision & Initial Beh Health	$20	$30	$40	$50	$60	$70
Follow-up Beh Health	$5	$6	$7	$8	$9	$10
Dental Services except for those listed below	$35	The greater of 10% of fees or $36	The greater of 20% of fees or $37	The greater of 40% of fees or $38	The greater of 60% of fees or $39	The greater of 80% of fees or $40
LCH&D Pharmacy	Drug Cost + $1	Drug Cost + $2	Drug Cost + $3	Drug Cost + $4	Drug Cost + $5	Drug Cost + $6
Insertion of Mierna/Kyleena IUD - Includes Supplies & Services	$290	$300	$310	$320	$330	$340
Insertion of Nexplanon - Includes Supplies & Services	$545	$555	$565	$575	$585	$595
Root Canal - Anterior	$250	$260	$270	$280	$290	$300
Root Canal - Posterior/Pre-Molars	$300	$310	$320	$330	$340	$350
Root Canal - Posterior Molars	$350	$360	$370	$380	$390	$400
Crown:Porcelain - Includes Supplies & Services	$430	$440	$450	$460	$470	$480
Crown :Stainless Steel - Includes Supplies & Services	$352	$362	$372	$382	$392	$402
Dental Bridge - Includes Supplies & Services	$430 per unit (tooth)	$440 per unit (tooth)	$450 per unit (tooth)	$460 per unit (tooth)	$470 per unit (tooth)	$480 per unit (tooth)

For families with more than 12 persons, add $5,140 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 and Enrollment Associate for more information on the LCH&D 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, thatn the amount they would pay under the appllicable SFDS discount pay class level above.

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 _______________

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**

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 (No estudiante de tiempo completo)	1 mes de cheques de nómina o una declaración de la lista del empleador

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)

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____

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) :

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Documentation received by: ___________________________________Date________________

Signature: ____ Date:______________________________

Approved by: _______________________________________ Date: _____________________________