Robert C. Byrd Clinic

Sliding Fee Discount Program Agreement

Purpose: Robert C. Byrd Clinic (RCBC) offers a Sliding Fee Discount Program designed to provide discounted care to those who are uninsured (do not have insurance coverage, i.e. Medicare, Medicaid, or commercial insurance) or have very limited means to pay for their healthcare services.

By federal law, program eligibility is based on two criteria, patient household income and household size. RCBC will not discriminate based on age, gender, race, sexual orientation, creed, religion, disability, or national origin. The Federal Poverty Guidelines are used in creating and annually updating the sliding fee schedule to determine eligibility.

Guidelines for the RCBC Sliding Fee Discount Program:

1. **Notification**: An explanation of the RCBC Sliding Fee Discount Program and application form are available on our website, through social services and in clinic waiting areas.

2. **Provision of Services**: The Sliding Fee Discount Program is a patient assistance program that may provide discounts on normal and customary charges for medical visits for qualifying patients based on household size and income. Only medically necessary services performed by an RCBC provider at an RCBC clinic location are discounted under this program.

3. **Exclusions:** Service not covered include labs, radiology, radiologist professional fees, vaccines, acupuncture, DOT physicals and OSHA respirator evaluations. Some in-office procedures may not be covered by this program. It is the patient's responsibility to ask and understand if a procedure is covered under the discount arrangement. Mako Medical Laboratories offers a separate self-pay fee schedule.

   The RCBC Sliding Fee Discount Program does not discount or pay for hospital charges of any kind, in-patient or out-patient. The program does not discount or pay for prescriptions or medications. The program does not cover or discount any charges or fees associated with medical care provided through a referral made by an RCBC provider (such as care provided by a specialist physician to whom you have been referred, diagnostic or lab services, durable medical equipment, home health or nursing home services, physical therapy services or any other care related to a referral).

   Children and individuals with no income are encouraged to apply to the WV Department of Human Services for coverage through Children's Health Insurance Program or WV Medicaid. The RCBC Social Services and Billing Departments can assist patients with enrollment. *Please schedule an appointment*.

4. **Application Requirements:** Patients must submit a completed application and provide proof of income that is below 200% of the current federal poverty level (see chart below). To comply with federal law and for auditing purposes, income verification is a program requirement. By signing the Sliding Fee Discount Program application, the person authorized is confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored with usual and customary charges and payable immediately.

   If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the effective date on their application adjusted.

Once an application is approved, discounted services would apply beginning with the application authorization date and remain valid for a period of one (1) year, provided there is no change in annual household income or size. The discount will not be applied to services rendered prior to the authorization date. The patient is responsible for notifying RCBC of any change in household income or size. Applications must be re-submitted annually or if/when financial situation changes. RCBC staunchly complies with all HIPAA laws and regulations regarding the safeguarding of your personal health information, which includes financial data. A copy of our Notice of Privacy Practices and Sliding Fee Discount Program application can be found on our website at www.rcbclinic.org. You can also obtain an application or Notice of Privacy Practices from any member of our staff.

Once your application is complete and signed with copies of supporting proof of income, please contact our Business Office at 304-645-3220, ext. 2516 to schedule an appointment with a billing specialist. **VALID DRIVER'S LICENSE OR PHOTO ID must be presented at the time the application is submitted.**

Approved Sources of Income (Provide consecutive pay stubs for the past 60 day for all that apply):

- Pay Stubs – Wages, Salary, Commission, Bonuses, Sick Benefits or Profit Sharing
- Self-Employment Earnings
- Social Security, SSI or Welfare Benefit Statement
- Foster Care or Guardianship payments
- Complete Tax Forms with Federal 1040 and W2s from most recent year
- Veterans Benefits
- Disability, Black Lung or Workers Compensation Benefits
- Retirement Benefits
- Unemployment
- Child Support or Alimony
- Annuity Payments, Royalties, Dividends, Rental Income, etc.
- Student Loans

2024 Federal Poverty Guidelines						
Household Size	**Annual Income**	**Below 100%**	**100% Monthly**	**133% Monthly**	**150% Monthly**	**200% Monthly**
1	15,060		1,255	1,669	1,883	2,510
2	20,440		1,703	2,265	2,555	3,406
3	25,820		2,152	2,862	3,228	4,304
4	31,200		2,600	3,458	3,900	5,200
5	36,580		3,048	4,054	4,572	6,096
6	41,960		3,497	4,651	5,246	6,994
7	47,340		3,945	5,247	5,918	7,890
8	52,720		4,393	5,843	6,590	8,786
Each additional member of household, add	$5,380		$448	$596	$672	$896
Sliding Fee Discount Office Visit		**$20**	**$20**	**$58**	**$80**	**$100**
Sliding Fee Discount NEW PATIENT Visit		**$30**	**$30**	**$74**	**$100**	**$130**
Sliding Fee Discount ONMM Visit		**$40**	**$40**	**$96**	**$132**	**$168**

Income Exceeding 200% of the Federal Poverty Level: Usual & Customary Charges Apply

5. **Payment for Discounted Services:** Patients who qualify for the program are responsible for payment of the nominal fee in their respective tier. This fee is expected at the time of service unless other arrangements have been made in advance of the appointment with a billing specialist. If the discounted fee is not paid at the time of service, usual and customary charges will apply, and future appointments may not be scheduled until the account is in good standing. At no time will the facility discriminate in the provision of services to an individual (i) because the individual is unable to pay; (ii) because payment for those services would be made under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP); or (iii) based upon the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.

6. **Other Insurance Coverage:** If you have any form of insurance coverage, RCBC is required by our payor contracts to bill your insurance for your medical visit charges. Co-pays, co-insurance or deductibles apply.

   RCBC can assist with coverage for certain types of care through other programs such as Family Planning, VFC, Breast and Cervical Cancer Screening Programs, Bonnie's Bus and others.

7. **Remain in Good Standing:** RCBC maintains the right to remove a patient from the Sliding Fee Scale program and reserves the right to dismiss a patient from the practice for not showing up for scheduled appointments (more than two no-shows annually is grounds for program dismissal), not making payments at the time of service, not following requirements of a controlled substance contract (if applicable), and not completing an application annually with proof of updated household income and size documentation.

Statement of Understanding:
I have read and fully understand and acknowledge the program purpose and guidelines and agree to comply with these provisions in their entirety. I understand the Sliding Fee Discount Program is not a form of insurance. I attest the information I have given concerning my family's gross monthly/annual income from all sources is true, accurate, and complete to the best of my knowledge. I have given this information concerning my financial situation and my means/ability to pay, for the purpose of procuring, for my own and my family's benefit, the discount qualified for under the "Sliding Fee Program" guidelines. I understand this discount applies only to the care provided at RCBC.

I agree to report any changes in my household's size, income or insurance coverage to RCBC and understand my application may be reviewed by an auditor of any patient assistance program from which I may benefit.

I understand my discount status will be reviewed annually. At the time of the scheduled renewal or at any time when changes in either family size or income occur, my discount percentage may be adjusted. If RCBC has reason to suspect the information I provided is untrue, misleading or incomplete, or if changes in household's size, income or insurance coverage are not reported as agreed, RCBC reserves the right to initiate a review of my program status, at which time I will be asked to supply documentation supporting my current situation. If I refuse such a review, RCBC will no longer provide a discount on my account.

Applicant Printed Name: _____ Date of Birth: _____

Signature: _____ Date of Application: _____

For Office Use Only:
Signature of Billing Specialist: _____ Date: _____

❒ Approved Effective Date: _____

❒ Denied Reason for denial: _____

Robert C. Byrd Clinic

Sliding Fee Discount Program Application

Please complete all sections of this application. All information is strictly confidential.
Proof of gross household income for the past 3 months is required for all family members living in the household including wages, salaries, tips, pensions, social security benefits, VA benefits, unemployment, SNAP, child support, Worker's Compensation benefits, alimony, etc. A photo ID is required at the time the application is submitted.

Applicant Full Name (Print): _____ Date of Birth: _____

Mailing Address: _____ State:_____ Zip: _____

Cell Phone: _____ Home Phone: _____

Family/Household Information: List all dependents living in your household including spouse, biological or legally adopted children, etc.

Household Member First and Last Name	Date of Birth		Relationship to Patient	Monthly Income	Type of Insurance and Group ID
Patient Income Disclosure Type of Income – Please reference the program agreement for all that apply			Weekly	Monthly	Annual
1.					
2.					
3.					
4.					

If you do not have any income, please explain your living situation (food/shelter/help from family, etc.)

_____

_____

_____

By signing below, I permit RCBC to request and verify proof of income as noted above and understand that additional information may be requested. I understand and agree to comply with all terms in the RCBC Sliding Fee Discount Program agreement. I attest that I have correctly presented my income and disclosed all insurance coverage I have at present. I agree to pay any balances on my account. I agree to report any changes that could affect my eligibility to RCBC, including changes to family size, income or health insurance coverage.

Applicant Signature: _____ Date: _____