Sliding Fee Scale Policy

To ensure cost is not a barrier, THRIVE offers discounted medical care for patients who are uninsured or have low income. The amount each person pays is based on the federal income levels. Each year the federal government sets a Federal Poverty Level (FPL) and new income levels that qualify patients for discounted care. The income levels are based on a patient's gross income (how much money you make each year before taxes are taken out). We can help you calculate your household income compared to the FPL, or you can use this online calculator. THRIVE uses your income level to determine how much you pay towards the cost of your care, as shown in Table 1 below.

Out of Pocket Maximum (OOPM)

In addition to the sliding fee scale, we have also set a limit on the amount you will pay out of pocket in a calendar year. Once you have reached your out of pocket maximum, we will still bill your insurance for services, but you will not be required to pay any co-pays. All your medical bills, even those from other clinics, hospitals or pharmacies, count towards your maximum amounts, but you are responsible for tracking and documenting those costs and notifying us when you have reached your maximum. Please see a sample tracking sheet attached to this policy.

Table 1: Explanation of Out of Pocket Charges

Household Income	Out of Pocket Charge for each visit (until OOPM reached)	Out of Pocket Maximum (OOPM)
At or below 100% of FPL	$0	$0
101% to 200% of FPL	$10	No more than 5% of gross annual income
201% to 300% of FPL	$25	No more than 7% of gross annual income
301% -500% of FPL	$50	No more than 10% of gross annual income
Over 500%	Full cost	None

Application Process

To qualify for the Sliding Fee Scale, you must fill out an application (Attachment 1) and provide proof of your "household" gross annual income.

A "household" includes legal children, a civil union partner or married spouse, and legal dependents. It does not include anyone else who lives with you, even if they are related. Annual gross income includes salary, unemployment benefits, disability or social security benefits, investment income or other sources of income that support the household. You should bring proof of all of the household income for yourself and everyone in your household.

The following documents are can be used for proof of income:

- Most recent tax return
- 2 most recent pay stubs from employer, no older than three months
- Most recent W-2 or 1099
- Letter from employer stating cash earnings that is signed by your employer or supervisor
- Letter from the Social Security Administration documenting your SSI or SSDI benefits
- Letter from the Social Security Administration documenting that you are ineligible for government benefits
- Letter detailing unemployment benefits from your state unemployment office
- Military Leave and earnings statement
- A signed affidavit stating you have no source of income

THRIVE has staff who can help you with this application. Please ask to speak with one of them.

Attachment 1: Sliding Fee Application

It is the policy of THRIVE to provide services to all persons in need, regardless of income and/or the inability to pay. Please complete the following information so that we can determine your eligibility for discounted services. You will be reassessed for the sliding scale every XX months and you will be required to provide updated proof of income.

Name: ____

Preferred Name: _____________________________ **Date of Birth:** ________________________

INSURANCE (check all that apply)

☐ Medicaid ☐ Medicare ☐ Private/Employer ☐ Don't know

HOUSEHOLD

A "household" includes anyone that is found to be the applicant's (you) legal dependent, including children in your legal custody, a civil union partner or married spouse. Please list the name of individuals in your household that you are financially responsible for.

Name of Dependent	Relationship to You

Household Size = _________________

ANNUAL HOUSEHOLD INCOME

Verified Source of Income	Self	Partner	Other	Total
Gross wages, salaries, tips, etc.				
Social Security (SSI or SSDI)				
Unemployment Benefits				
Investment Income				
Other Income				
Total Income				

PLEASE READ AND SIGN

I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charged the full fee of my visit if I do not bring in documentation of income within 10 days of applying for the Sliding Scale program. I understand that I am required to notify THRIVE if my income level changes or if I become insured. If there are changes, I will be reassessed for the sliding fee scale. I understand that this program is only active for XX months and I will have to reapply at the end of the XX-month period.

Patient or Guardian Signature: ____

Date: _______________________

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☐ **$0 (<100%)** ☐ **$10 (101-200%)** ☐ **$25 (201-300%)** ☐ **$50 (301-500%)**

☐ **Full charge - income is >500%**

Reviewed By	
Effective Date	
Expiration Date	

Attachment 2: Out of Pocket Tracking Sheet

This form can be used to track your out of pocket medical expenses. Qualifying expenses are those you are personally responsible for including, but are not limited to: primary care visits, mental health and substance abuse counseling, dental care, ophthalmology care, dermatology care, prescriptions, medical insurance copays, and over-the-counter medications. Not included are any costs paid by your insurance company.

Once you reach your out of pocket maximum, bring this form and copies of your bills/receipts to a THRIVE staff member. Staff will also help you calculate your annual out of pocket maximum.

Description	Date	Amount	Running Total
Example: copay for prescription medications	*1/3/23*	*$25*	*$25*
Example: THRIVE PrEP visit copay	*2/6/23*	*$10*	*$35*

My percentage of Federal Poverty Level (FPL) is ______________________%

My maximum out of pocket cost/per calendar year is $___________________