Squirrel Hill Health Center
Application for Financial Assistance Instructions

Squirrel Hill Health Center ("SHHC") provides medical, dental, behavioral health and pharmacy services to all patients regardless of their ability to pay. For individuals or families who are uninsured or underinsured, SHHC offers a sliding fee program with discounts for patients whose household income falls below 200% of the federally established poverty level. Patients whose household incomes fall at or below 100% of the poverty level are charged only a nominal fee. Households with income falling between 101-200% will receive a discount from the full charge depending the level approved. SHHC updates the poverty guidelines annually, as soon as the Federal Government releases new rates.

Any patient who has no insurance or has limited insurance coverage is encouraged to apply for our sliding fee scale using the attached application. Once SHHC receives the application and all necessary proof of income, it will be reviewed and the level of discount approved. Determinations will be made within 30 days of receipt. If the household income is above 200% of poverty, we are not permitted to provide any sliding fee discount. Those patients will then be eligible for an interest free payment plan. If the patient is insured but meets the income requirements for a discount, SHHC will submit all charges to the insurance carrier first and then any patient balance will be eligible for the sliding fee program.

Children are eligible for the Sliding Scale only if they are ineligible for or have been denied Medical Assistance or Chip coverage. If parents need help applying for Medical Assistance or Chip coverage, SHHC will refer them to an agency that can help them though that process.

Patients who do not qualify for a discount, or who still have a balance due after the Sliding Payment Scale is applied, are eligible for an interest free payment plan. Patients interested in a payment plan must contact the billing liaison or the dental office staff to arrange a payment plan.

For all non-urgent services, especially dental services, the sliding fee application should be completed prior to the first appointment. In the case of a true emergency, patients will not be denied treatment while the sliding fee application is being completed and approved. Patients should then submit the application within 30 days of their first appointment. If you cannot supply the documents within that time, please discuss with the billing liaison or outreach and enrollment who may grant an extension. If you have difficulty understanding or completing the form, the SHHC Outreach and Enrollment, billing liaison or staff can help you with this process. **Failure to complete the form will result in you being responsible for 100% of the charges incurred along with any lab charges from Quest. It is in your best interest to apply for the sliding fee scale.**

During the application process, you will be responsible to pay the nominal fee at each visit. If, after the application has been approved you do not qualify for the nominal fee level, you will be billed the difference between the nominal fee and your approved level. On future visits, you will be responsible for making the appropriate payment. Again, if you cannot make the full payment, a non-interest payment plan can be arranged.

Below is a summary of the sliding fee payments:

	MEDICAL	**DENTAL**	**BEHAVIORAL HEALTH**	**PHARMACY PRESCRIPTIONS**
100% poverty level or below	$15.00	$25.00	$5.00	Cost of prescription plus $3.00
101-125% poverty level	$25.00	80% discount	$6.00	Cost of prescription plus $4.00
126-150% poverty level	$35.00	60% discount	$7.00	Cost of prescription plus $5.00
151-175% poverty level	$45.00	40% discount	$8.00	Cost of prescription plus $6.00
176-200% poverty level	$55.00	20% discount	$9.00	Cost of prescription plus $7.00
201% poverty level or above	Full charges	Full charges	Full Charges	Full Charges

There may be additional charges for some dental services, which are considered non-covered or elective.

If you have any questions regarding this application, please call 412-904-5285. Once the application is completed, please send along with the necessary supporting documentation to:

Squirrel Hill Health Center
CAC/Outreach & Enrollment
4516 Browns Hill Road
Pittsburgh, PA 15217

Squirrel Hill Health Center
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Proof of income:
SHHC requires independent documentation of the most current information regarding your household income. The preference in order of the most current would be:

- Three (3) most recent pay stubs, showing YTD earnings
- Current Statement of Pension, Social Security, Disability, Worker's Compensation, and/or Unemployment benefits
- Current Statement of Public Assistance (welfare) cash benefits
- Current Medical Assistance denial showing income
- Current Letter of wage verification from employer

If none of the above information is available, please speak with the billing liaison as to what other information may be used.

Household information:

Patient Name: _____ Date of Birth: _____
Address: _____
_____
Home phone: _____ Cell phone: _____
Work/Other phone: _____

1) Are you a student? __ Yes __ No Full Time _____ Part Time _____

2) Are you listed as a dependent on someone else's taxes? __ Yes __ No

3) Are you or anyone in the household currently pregnant? __ Yes __ No Name: _____

4) Do you have medical coverage? __ Yes __ No Name/type of insurance: _____

	Please list all people living in your household for whom you provide financial support OR who provide financial support for you.			
Name	**Relationship**	**Date of Birth**	**Child Under 18 Eligible for Chip**	**Employer and number of hours/week**
1.	SELF			
2.				
3.				
4.				
5.				
6.				
7.				

Which services/benefits have you or someone in your household applied for, and have you received them or been denied?

	Applied	Denied	Received, date, monthly amount?
Medical Assistance	_____	_____	_____
Unemployment	_____	_____	_____
Social security	_____	_____	_____
Disability	_____	_____	_____
Worker's Comp	_____	_____	_____
Child support	_____	_____	_____
Alimony	_____	_____	_____
Food stamps	_____	_____	_____
Public assistance (welfare)	_____	_____	_____
Other benefits	_____	_____	_____

How the Sliding Payment Scale Works*

Below is a chart that shows some common charges a patient may experience at SHHC. Based on the discount level approved, this chart shows how much the patient would pay for the service.

Type of visit:	Full Price	Nominal Fee	80% Discount	60% Discount	40% Discount	20% Discount	Ineligible or fail to complete
New patient limited office visit 99203	$231.00	$15.00	$25.00	$35.00	$45.00	$55.00	$231.00
Established patient limited office visit 99213	$173.00	$15.00	$15.00	$30.00	$45.00	$60.00	$173.00
45-50 Therapy Session 90806	$120.00	$ 5.00	$6.00	$7.00	$8.00	$9.00	$120.00
Prenatal Visit 4-6 59425	$209.00	$15.00	$25.00	$35.00	$45.00	$55.00	$209.00
Comprehensive Oral Exam with Complete X-ray D0150 & D0210	201.00	$25.00	$40.20	$80.40	$120.60	$160.80	$201.00

***Please note this chart provides estimates only. Additional fees and charges may apply.**

By signing below, I understand more information may be requested before my eligibility can be determined.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete, or false information that I provide or someone else provides for me could cancel my application for financial assistance.

All adult household members who sign below authorize the release of any medical, financial, or employment information that relates directly to their health care or financial assistance eligibility. This information may be released to any health care providers with whom SHHC is working to secure ancillary medical services on behalf of the patient. All information provided will remain confidential under the provisions of HIPAA federal regulations and will not be shared with any other governmental agency.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the services covered by this application. For example, insurance payments, government program payments, award from a lawsuit, or any other payment.

If I receive financial assistance, I agree to alert the Squirrel Hill Health Center of any changes, which could affect eligibility, including changes to family size, income, and health insurance coverage. I understand that if I or anyone in the household becomes eligible for public assistance programs or health insurance, that I will apply for these programs and provide the new coverage to SHHC.

_____ _____

Signature Date

_____ _____

Signature Date

Return the information to:

Squirrel Hill Health Center
Attn: CAC/Outreach & Enrollment
4516 Browns Hill Road
Pittsburgh, PA 15217

Important phone numbers:

Medical Appointments:	412-422-7442
Dental Appointments:	412-697-7997
CAC/Outreach & Enrollment::	412-904-5285
Fax number	412-904-5025

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