Squirrel Hill Health Center
Application for Financial Assistance Instructions

Squirrel Hill Health Center ("SHHC") provides medical, dental, and behavioral health services to all patients regardless of their ability to pay. **Any patient who has no insurance, limited insurance coverage, or is experiencing financial hardship 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 determined based on the current year's posted federal poverty guidelines. The Federal Poverty Guidelines are updated annually and posted by the US Department of Health and Human Services. Determinations will be made within 30 days of receipt of the completed application. Submitted applications are strictly confidential. Information is not shared with any person(s) or organizations outside of SHHC.

If the household income is above 200% of poverty, per federal guidelines we are not permitted to provide any sliding fee discount. If the patient is insured but meets the income requirements for a discount and our contract with the insurance plan allows it, 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 fee 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, an Outreach and Enrollment (OE) Coordinator can help them though that process.

All patients are eligible for an interest free payment plan. Patients interested in a payment plan must contact the billing department 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 but must be complete within 30 days of the first visit. In the case of a true emergency, patients will not be denied treatment while the sliding fee application is in process. If you cannot supply the documents within that time, please discuss with the OE Coordinator who may grant a 30 day extension. If you have difficulty understanding or completing the form, the OE Coordinator can help you with this process. **Failure to complete the form will result in you being responsible for 100% of the charges incurred. This includes any discounts that would be extended to outside facilities based on approval of this application. It is in your best interest to apply for the sliding fee scale.**

During the application process, you will be responsible for paying the minimum nominal fee at each visit. If, after the application has been processed and you do not qualify for the program or you qualify for a higher nominal fee level, you will be billed the difference. On future visits, you will be responsible for making the appropriate payment as indicated in your approval letter. Again, if you cannot make the full payment, a non-interest payment plan can be arranged.

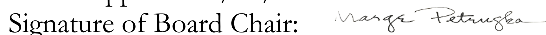
Below is a summary of the sliding fee payments:

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

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

If you have any questions regarding this application, please call 412-442-7442 x 9904. Once the application is completed, please send along with the necessary supporting documentation to:
Squirrel Hill Health Center
Outreach and Enrollment
4516 Browns Hill Road
Pittsburgh PA 15217

Board Approval: 1/28/25
Signature of Board Chair:



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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 an OE coordinator regarding 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**	**Number of Hours per Week**
1.	SELF			
2.				
3.				
4.				
5.				
6.				
7.				

Board Approval: 1/28/25
Signature of Board Chair: Marge Petruska

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.**

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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. I understand more information may be requested before my eligibility can be determined.

Adult household members who sign below authorize the release of any medical, financial, or employment information that relates directly to healthcare or financial assistance eligibility for all person(s) listed in this application. 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, Aflac, award from a lawsuit, or any other payment.

If I receive financial assistance, I agree to alert 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, I will apply for these programs and provide the new coverage to SHHC.

I understand that, upon approval, SHHC makes every effort to ensure I will receive comparable discounts at other facilities involved in my care coordinated here. I understand that these are typically just discounts and may still result in my being financially responsible for all or a portion of those outside facility bills.

______________________________ ______________________
Signature Date

______________________________ ______________________
Signature Date

Return the information to: Squirrel Hill Health Center	**Important phone numbers:** Medical Appointments:	412-422-7442 option 1
Attn: Outreach & Enrollment	Dental Appointments:	412-697-7997
4516 Browns Hill Road	Outreach& Enrollment:	412-442-7442 ext. 9904
Pittsburgh, PA 15217	Fax number Billing Department	412-904-5025 412-422-7442 option 6
Revised 3/10/16-SB		

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