Sliding Fee Application Process Guide

The Sliding Fee Program provides assistance with medical bills for those who qualify.

To apply complete the Sliding Fee Application and return with the following required documentation:

1. Current New York State Income Tax return which indicates Adjusted Gross Income (This is not required but helpful in making a determination of your application)

2. A New York State Medicaid screening/determination (if available)
   Please call 585-396-6463 or 396-6445 over 65 - please call 585-393-2979

3. Pay Stubs – one each from the last 4 consecutive pay periods.

For other types of income, the list on the first page of the Sliding Fee Application is provided to assist you in choosing the appropriate documentation.

INCOMPLETE APPLICATIONS WILL BE RETURNED UNPROCESSED

For assistance in the application process call our Financial Counselors at (585)396-6512, (585)396-6511 or (585)396-6029
Sliding Fee Application

The Sliding Fee Program provides assistance with medical bills for those who qualify. To apply, complete the Sliding Fee Application and return with required documentation.

Date of Request ______________________

Patient’s Name: ____________________________ DOB ______________________

Phone (Home) ____________________________ (Cell) ______________________

Mailing Address: ____________________________

Guarantor Name: ____________________________

Please list all household members including minor children under 21 that live with you (even if they are not applying for Sliding Fee at this time.) If more space is required, use an additional sheet.

First and Last Name Date of Birth Relationship to Patient

<table>
<thead>
<tr>
<th>First and Last Name</th>
<th>Date of Birth</th>
<th>Relationship to Patient</th>
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</thead>
<tbody>
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</table>

Income Amount Please indicate if this is weekly, monthly, etc.

<table>
<thead>
<tr>
<th>Wages (includes self-employment)</th>
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<tbody>
<tr>
<td>Social Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment Compensation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other * see list below - please indicate type</td>
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</table>

Your Estimated Annual Income: $________________________

Please return copies of the following documents with your completed Sliding Fee Application

- 1 month of wage/income statements
- If unemployed, please provide all sources of other income such as but not limited to: Unemployment Award Letter, Social Security/Disability Benefit Letter, etc.
- Other forms of income that may apply to you, please include proof of: *Alimony, Child Support, Military Family Allotments, Pensions/IRA/Retirement/Annuities, Income from Rent, Income from Dividends/Interest.
- A copy of your most recent Income Tax Return which indicates Gross Income (this is not required but helpful in making a determination of your application)
- If you are Self-Employed- you MUST include a copy of most current Income Tax Return and a copy of the following forms that apply to your type of Self Employment Business:
  - Schedule C; Net Profit or Loss from Business (if applicable)
  - Form 8825 Profit or Loss from Rental Income (if applicable)
  - Form 8825 Net Rental Real Estate Income (if applicable)
  - Schedule F Profit or Loss From Farming (if applicable)
Please Note: Based on review of income, you may be asked to submit Medicaid Status Information.

I certify that the information is true and accurate to the best of my knowledge. I understand that this application is made so that Thompson Health can determine my eligibility for Community Care Benefits as related to New York State Charity Care Guidelines effective January 26, 2018. I understand that this information may be used in discussions with another party to help determine eligibility.

Signature of Person Making Request

The following income guidelines may help determine if you are eligible for Thompson Health’s Financial Assistance Program. The intent of providing the following information is to enable you to determine if you or your household may be eligible for this program. If you are in doubt we encourage you to submit this application for consideration.

### FINANCIAL ASSISTANCE APPROVAL GUIDELINES

<table>
<thead>
<tr>
<th>Financial Assistance % Allowance</th>
<th>% of Federal Poverty Level</th>
<th>1 Person</th>
<th>2 Person</th>
<th>3 Person</th>
<th>4 Person</th>
<th>5 Person</th>
<th>6 Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% Up to 200%</td>
<td>2018 Federal Poverty Levels (FPL)</td>
<td>$ 12,140.00</td>
<td>$ 16,460.00</td>
<td>$ 20,780.00</td>
<td>$ 25,100.00</td>
<td>$ 29,420.00</td>
<td>$ 33,740.00</td>
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<tr>
<td>80% 201% - 250%</td>
<td>$ 24,280.00</td>
<td>$ 32,920.00</td>
<td>$ 41,560.00</td>
<td>$ 50,200.00</td>
<td>$ 58,840.00</td>
<td>$ 67,480.00</td>
<td></td>
</tr>
<tr>
<td>60% 251% - 300%</td>
<td>$ 30,350.00</td>
<td>$ 41,150.00</td>
<td>$ 51,950.00</td>
<td>$ 62,750.00</td>
<td>$ 73,550.00</td>
<td>$ 84,350.00</td>
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</tr>
<tr>
<td>40% 301% - 350%</td>
<td>$ 36,420.00</td>
<td>$ 49,380.00</td>
<td>$ 62,340.00</td>
<td>$ 75,300.00</td>
<td>$ 88,260.00</td>
<td>$ 101,220.00</td>
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</tr>
<tr>
<td>20% 351% - 400%</td>
<td>$ 42,490.00</td>
<td>$ 57,610.00</td>
<td>$ 72,730.00</td>
<td>$ 87,850.00</td>
<td>$ 102,970.00</td>
<td>$ 118,090.00</td>
<td></td>
</tr>
<tr>
<td>0% Over 401%</td>
<td>$ 48,560.00</td>
<td>$ 65,840.00</td>
<td>$ 83,120.00</td>
<td>$ 100,400.00</td>
<td>$ 117,680.00</td>
<td>$ 134,960.00</td>
<td></td>
</tr>
</tbody>
</table>

Each additional household member add $4320

Example: A one person household with a gross annual income of $28,000 would receive a Financial Assistance allowance of **80%** as they would be below the 80% income of $30,350 but above the 100% income of $24,280.

Please mail completed application and necessary documents to:

Thompson Health, 3170 West Street, Suite 150, Canandaigua NY 14424

To speak to a Financial Counselor:

If your last name begins with:

- A-G: 585-396-6029
- H-P: 585-396-6511
- Q-Z: 585-396-6512

Incomplete applications will be returned unprocessed.

For Office Use Only:

- Date Received in PFS: _____/____/____
- Sliding Fee Pending added: _____/____/____
- Approved By: ____________________________
- Rejected By: ____________________________
- Reason: ______________________________________

Applicant advised on _____/____/____ by letter.