Document Title:	Last Reviewed Date:
Sliding Fee Discount Schedule	02/17/2024
Category:	**Original Creation Date**
Administrative	03/31/2020
Issuing Department:	**Policy Number:**
Board of Directors	1238

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:
This policy establishes the eligibility and administration of the Sliding Fee Discount Program (SFDP) that provides a schedule of discounts to eligible patients based on their family/household size and income, recognizing same sex marriage in the context of defining family.

Policy:
No patient will be declined service because of an inability to pay for services. The SFDP offered at Axis is established in accordance with the guidelines set forth by the Health Resource and Services Administration (HRSA) and applies to the required and additional services within the Axis Health System (Axis) Community Health Center (CHC) approved scope of project. Sliding fee discounts are also provided by formal referral partners for services not provided directly by the Axis CHCs where appropriate. The SFDP is available for all other Axis services, based on guidance and requirements set forth by the State of Colorado. Axis SFDP may be accessed by all Axis patients who meet eligibility requirements which are solely based on household size and income.

Sliding scale discounts will be based on the most recent Federal Poverty Guidelines (FPG), which are updated annually. Patients qualifying for a sliding scale discount will be expected to pay the nominal fee or partial discount indicated on the SFDP schedule located within the procedure for all in-scope services.

Axis sliding fee discount schedule will have four discount classes for household incomes greater than 100% of the Federal Poverty Level (FPL) and at or below 200% FPL, which is based on current, published FPG, tied to gradations in income levels and household/family size.

Axis sliding fee discount pay classes are identified as Slide A – Slide F; Slide F - above 200% of poverty receive no discount:

- Slide A: Patients with incomes at or below 100% FPL receive a full (100%) discount and will be asked to pay a nominal charge as set by the Board.
- Slides B – E: Patients with incomes ranging from greater than 100% FPG to at or below 200% FPL will pay discounted flat fees as set by the Board. There are four (4) different sliding fee levels within this income range.
    - Slide B: >100% to 125%
    - Slide C: >125% to 150%
    - Slide D: >150% to 175%
    - Slide E: >175% to 200%
- Slide F: Patients with income above 200% of FPL receive no discount and pay full fee.

AHS participates in Title X Program to provide individuals with comprehensive family planning services. The services require a different set of pay classes for the SFDP applicable to those services. Pay classes for these services are identified as follows:

KEYWORDS: Board Approved, HRSA

- Slide A: Patients with incomes at or below 100% FPL receive a full (100%) discount and will not be asked to pay a nominal fee.
- Slides B – E: Patients with incomes ranging from greater than 100% FPG to at or below 250% FPL will pay discounted flat fees as set by the Board. There are four (4) different sliding fee levels within this income range.
  - Slide B: >100% to 150%
  - Slide C: >151% to 185%
  - Slide D: >186% to 220%
  - Slide E: >220% to 250%
- Slide F: Patients with income above 250% of FPL receive no discount and pay full fee.

The SFDP application and proofs of income will be signed, reviewed by designated staff and filed. Determination of eligibility for sliding scale discounts will be done on an annual basis. Eligibility will be determined when the required documents are returned to Axis. The documentation must be returned within 14 days.

AXISHealth System

Document Title:	Last Reviewed Date:
Sliding Fee Discount Procedure	02/21/2024
Category:	**Original Creation Date**
Administrative	03/31/2023
Issuing Department:	**Policy Number:**
Revenue Cycle	1261

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:
This document outlines the procedure for the administration, management and documentation standards that support the availability of the Sliding Fee Discount Program (SFDP) Schedule.

Procedure:

A. Axis Health System (Axis) will make all patients aware of the SFDP through the following methods: Axis registration staff will offer the option of applying for the SFDP to all patients at check-in. Schedulers, eligibility workers, financial counselors, and case managers will also inform patients about the SFDP and assist with the application process. Any patient may request the SFDP Application & Instruction packet at any time. The SFDP availability is disclosed in English and Spanish via:

1. The Patient Enrollment Packet
2. The Axis website; and
3. Visible notices posted in the lobbies of all Axis clinical facilities.

B. Patients who qualify for the SFDP will pay a nominal fee or partially discounted fee per SFDP Schedule (Exhibit A). Insured patients who qualify for the SFDP will pay the lesser of their insurance co-pay or deductible or the nominal or partially discounted fee per the SFDP Schedule (Exhibit A) .

C. Applicants will be expected to provide all appropriate information for the completion of a SFDP Application.

D. Income is defined as earnings over a given period used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource while income is comprised of earnings. Income includes money received from: wages, unemployment compensation, worker's compensation, Social Security, public assistance, veteran's payments, pension benefits, retirement income, investment income, alimony, child support, assistance from outside the household and other income and earning sources. One of the following documents is required for verification of income:

1. Most recent paycheck stubs for a period of at least four weeks, annualized (could include unemployment income)
2. Statement from employer on company letterhead (if available) as to proof of wages (when check stubs are not used)
3. Statement from the Division of Unemployment Services
4. Statement of income determination from the Department of Housing
5. Most recent federal tax return, W-2 from most current year, 1099, veteran's benefits, Social Security Statement, Rental Income, or education assistance employment programs.
6. Patients with no visible means of support may complete a Self-Attestation of Zero Income (Exhibit B) form to attest they are currently receiving no income and unable to provide any other proof of income.

KEYWORDS: HIPAA, HRSA

7. Patients declining to provide income information, or the Self-Attestation of Zero Income (Exhibit B) will be considered ineligible for the SFDP.

E. Presumptive visits - Any patient may apply one time within a 12-month period for a "presumptive" sliding fee. This slide will be based on the family size and income indicated on the application. This "presumed" slide will be in effect until documentation is verified or until the 14-day period has lapsed.

F. If the required documentation is not returned in the required 14-day period, the patient will be sent a denial letter and the patient will be charged full fee for all services. The patient-may re-apply at any future time.

G. Using the income categories and appropriate family size below, patients will pay the appropriate charge as indicated. Axis defines family/household as follows:

1. Family refers to a group of two or more people related by birth, marriage (including same sex marriage), or adoption and includes foster care or legal guardianships for those who reside together.
2. Household refers to households maintained by a family (as defined in previous sentence) including additional non-family members that contributed income to support the family/patient in the last calendar year.

H. A patient unable to pay the SFDP fee may apply for the Conditional Fee Waiver (CFW) Program using the CFW Application. Axis patients, depending upon circumstances, may be eligible for consideration of an additional discount, up to and including a full discount depending upon qualification under the separate CFW.

I. Per HIPAA Privacy laws, patients may elect not to bill their insurance for services. A refusal to bill insurance form is available and can be found within the Billing and Collections Procedure. Failure to sign the Refusal to Bill Insurance form will not disqualify Community Health Center (CHC) patients from the SFDP.

J. The Board of Directors will review the sliding fee discount schedule and the nominal fee annually. The purpose of the evaluation is to ensure the program reduces financial barriers to care from the perspective of patients with incomes at or below 100% of the FPG. Evaluation of the Sliding Fee Discount Program includes:

1. A comparison of patient utilization stratified by income levels - " slide categories" by program service.
2. Patient experience data to evaluate the effectiveness of health center's sliding fee discount program in reducing financial barriers to care.
3. Amending the policy to implement changes as needed to reduce financial barriers to care.
4. Documentation that shows each nominal charge does not reflect the actual cost of the service being provided.

K. Staff will ensure that patient privacy and confidentiality is protected throughout the process.

L. Equipment and Supplies exceptions. As a health center program participant, Axis is committed to reducing barriers to care and improving health outcomes for patients. To facilitate access to supplies and equipment (i.e., dentures, IUDs) purchased from a third party, Axis will set charges to cover reasonable costs of the equipment or supplies. These items are specified on the respective fee schedules for medical, dental and pharmacy. This is also summarized in Exhibit A below.

M. Audits of the Sliding fee scale program will be done to ensure proper implementation, training, and compliance. The following procedure will be followed:

On a quarterly basis, Reimbursement Supervisor, or designee, will:

1. Pull list of patients on Sliding Fee Scale seen during previous quarter
2. Randomly select 10 patients per check-in office for chart audit
3. Review sliding fee scale documentation for correct income information and calculations.
4. Identified errors are recorded and corrected in the patient chart.
5. Areas for needed improvement are identified and training is provided to front desk staff.

Community Mental Health Center (CMHC) and Title X services

A. SFDP Exclusions related to Community Mental Health Center (CMHC) services only and do not apply to any of the Axis CHC sites:

1. The following CMHC services are considered ineligible for the SFDP:
   a. CMHC services provided to patients who reside outside of Colorado are not eligible for the SFDP; and
   b. CMHC DUI Education services are CMHC full fee services that aren't eligible for the sliding fee discount.
   c. CMHC Detox services are full fee services, eligible for a prompt pay discount, but are not eligible for the sliding fee discount.
2. Per HIPAA Privacy laws, patients may elect not to bill their insurance for services. A refusal to bill insurance form is available and can be found within the Billing and Collections Procedure. The Refusal to Bill Insurance form must be signed.
   a. Patients electing not to bill insurance are not eligible for the SFDP while this agreement is in effect.
3. Any patient admitted for ATU stay may apply at discharge and have coverage back to admit date.

B. Axis participates in Title X Program to provide individuals with comprehensive family planning services. The Title X SFDP Schedule will be utilized for all uninsured Title X / Family Planning services unless an exception is stated within this procedure. The Title X SFDP applies to all individuals or families with annual incomes at or below the 250 percent of the Federal Poverty Level (FPL). Patients with documented income of 100% or below FPL will not be charged. Axis will follow the Federal regulations and the current Colorado Department of Public Health and Environment (CDPHE) sliding fee scale for patients in the Title X program.
1. The Family Planning Financial Form will be utilized, indicating the patient desires confidential services.
2. Patients presenting for services and marking the visit "Confidential" on the Family Planning Financial Form may complete the Title X Self Declaration Form (Exhibit E) using only their income. No proof of income is required for this.
3. Title X SFDP Rate development will follow the Rate Development Procedure
4. Income Verification:
   a. Patient income verification obtained for other patient services at AHS may be used, rather than re-verifying income. Patients may also utilize the Title X Self Declaration Form (Exhibit E) to self-report.
   b. Income verification will not present a barrier to services.
   c. Title X SFDP schedule will be utilized to determine eligibility. This schedule is based solely on family size and income.
   d. Only the patient's reportable income is used and will not include other household members for Title X SFDP eligibility purposes.
   e. Patients at or below 100% of FPL must not be charged or billed for covered routine family planning clinic services unless patient has third party coverage. Third party coverage detailed below.

5. The Title X Sliding Fee Application will be completed, noting that the only reportable income is that of the patient and will not include other household members.
6. The term of the Title X sliding fee is for one year with the ability to reapply once it expires.
7. In situations in which a patient requests both Title X services and non-Title X services, the Title X slide will only apply for the Title X services and an AHS Sliding Fee Application must be completed for the non-Title X services.

Patients with Third Party Coverage:

a. Patients are assessed for third party coverage.
b. Patients covered by or eligible for third party insurance programs, including Medicare, may be eligible for a SFDP TITLE X discount.
c. Patients with third party coverage at or below 100% FPL will not be billed for patient responsibility portion.
d. Per HIPAA Privacy laws, patients may elect not to bill their insurance for services. A refusal to bill insurance form is available and can be found within the Billing and Collections Procedure. Failure to sign the Refusal to Bill Insurance form will not disqualify Title X patients from the SFDP.

8. Confidential visits will only be billed to Third Party Payers who have the capability of providing a confidential EOB. (i.e. Medicaid). If the payer cannot ensure confidentiality for EOBs, the fee will not exceed the appropriate Title X SFDP patient responsibility.
9. In instances the patient with insurance does not qualify for the Title X SFDP, the fees will be adjusted off.

TITLE X

2024 Sliding Fee Discount Schedule					
	Annual Income Range				
	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Number in Household	Under 100% FPL	101%-150%	151%-185%	186%-220%	221%-250%
1	$0-$15,060	$15,061-$22,590	$22,591-$27,861	$27,861-$33,132	$33,133-$37,650
2	$0-$20,440	$20,441-$30,660	$30,661-$37,814	$37,815-$44,968	$44,969-$51,100
3	$0-$25,820	$25,821-$38,730	$38,731-$47,767	$47,767-$56,804	$56,805-$64,550
4	$0-$31,200	$31,201-$46,800	$46,801-$57,720	$57,721-$68,640	$68,641-$78,000
5	$0-$36,580	$36,581-$54,870	$54,871-$67,673	$67,673-$80,476	$80,476-$91,450
6	$0-$41,960	$41,961-$62,940	$62,941-$77,626	$77,627-$92,312	$92,313-$104,900
7	$0-$47,340	$47,341-$71,010	$71,011-$87,579	$87,580-$104,148	$104,149-$118,350
8	$0-$52,720	$52,721-$79,080	$79,081-$97,532	$97,532-$115,984	$115,985-$131,800
For each additional person add	$5,380 to annual income	$8,070 to annual income	$9,953 to annual income	$ 11,836 to annual income	$13,450 to annual income
Patient cost	$0.00	$15.00	$20.00	$25.00	$30.00

Exhibit A

2024 Sliding Fee Discount Schedule					
Annual Income Range					
CareLogic ^	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Intergy	A	B	C	D	E
Number in Household	Under 100% FPL	101% - 125%	126% - 150%	151% - 175%	176% - 200%
1	$0-$15,060	$15,061-$18,825	$18,826-$22,590	$22,591-$26,355	$26,356-$30,120
2	$0-$20,440	$20,441-$25,550	$25,551-30,660	$30,661-35,770	$35,771-$40,880
3	$0-$25,820	$25,821-$32,275	$32,276-$38,730	$38,731-$45,185	$45,186-$51,640
4	$0-$31,200	$31,201-$39,000	$39,001-$46,800	$46,804-$54,600	$54,601-62,400
5	$0-$36,580	$36,581-$45,725	$45,726-$54,870	$54,871-$64,015	$64,016-$73,160
6	$0-$41,960	$41,961-$52,450	$52,451-$62,940	$62,941-$73,430	$73,431-$83,920
7	$0-$47,340	$47,341-$59,175	$59,176-$71,010	$71,011-$82,845	$82,846-$94,680
8	$0-$52,720	$52,721-$65,900	$65,901-$79,080	$79,081-$92,260	$92,261-$105,440
For each additional person add	$5,380 to annual income	$6,725 to annual income	$8,070 to annual income	$9,415 to annual income	$10,760 to annual income
FQHC & CMHC Psych Services	$15.00	$20.00	$25.00	$30.00	$35.00
CMHC BH	$5.00	$10.00	$15.00	$20.00	$25.00
Lab Services	$0	$7.00 per lab	$8.00 per lab	$9.00 per lab	$10.00 per lab
Oral Health Services	See dental Fee schedule	60% discount	50% discount	40% discount	30% discount
Dental Labs	100% of Lab Cost	100% of Lab Cost	100% of Lab Cost	100% of Lab Cost	100% of Lab Cost
Supplies/Devices	At reasonable Cost	At reasonable Cost	At reasonable Cost	At reasonable Cost	At reasonable Cost
ATU (per day)	$50.00	$75.00	$100.00	$125.00	$150.00
CareLogic ^	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5

^ Further reductions for those at 200% below FPG may be through the Conditional Fee Waiver available based on evaluation and application

** For patients < 100% FPG AHS provided oral health services are at the per visit flat rate instead of a % of charges.

Exhibit B
Self-Attestation of Zero Income

Patient Name _____ Patient Number(s) _____

Axis Health System (Axis) supports the concept that patients should be monetarily invested in their care. Axis will assess a patient's ability to pay and discount services appropriately to remove financial barriers in accessing care through the *Sliding Fee Discount Program (SFDP).* As part of this assessment, AHS requires verification of the household size and income of any patients requesting financial assistance with the *SFDP*.

Axis has several options for proof of income, and we ask your cooperation in supplying the required information. There may be limited exceptions when proof of income cannot be provided, and this form is a mechanism to remove that barrier. In these rare instances, we ask your honesty and cooperation in completing this attestation. This information is to be used for the purpose of determining your eligibility for sliding fee discounts an d will be relied upon for federal compliance with offering the Sliding Fee Discount Program to you. This information will be kept strictly confidential and is only good for up to one year, at which point re-application for the Sliding Fee Discount is required.

PATIENT CERTIFICATION

I, _____, do hereby certify that I do NOT receive income from ANY source . I understand sources of income include, but are not limited to, the following:

- Money, wages, and salaries
- Regular payments from social security, railroad retirement, unemployment compensation, workers' compensation, veterans' payments, public assistance (including Temporary Assistance for Needy Families (TANF), Aid for Needy or Disabled and Supplemental Security Income (SSI))
- Alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions. (Including military retirement pay), and regular insurance or annuity payments.

By signing below, I understand and attest that I do not currently have any of the sources of income noted above supporting me, my family or my household. I solemnly swear that this information is true, accurate, and complete to the best of my knowledge and that any falsification, omission, or concealment of material fact may subject me to disqualification from the SFDP in perpetuity and will result in all discounts being revoked and the full balance of the account(s) restored and payable immediately.

I also acknowledge this Self Attestation of Zero Income will be used to assess my eligibility for sliding fee discounts and I will be required to pay the appropriate established discounted fee at the time of service for any care I receive at Axis, unless other arrangements have been made. I understand this form is only effective for one (1) year from the date of approval.

_____ _____
Signature Date

Exhibit C (Continued)
Self Attestation – Spanish Version
Testimonio personal de no recibir ingresos

Nombre del paciente _____Número(s) del paciente

Axis Health System (Axis) apoya el concepto de que los pacientes deben invertir monetariamente en su atención médica. AHS determinará la capacidad del paciente para pagar y descontará los servicios de la manera adecuada con el fin de eliminar los obstáculos de acceso a atención médica por medio del *Programa de descuentos de tarifas reducidas*. Como parte de esta determinación, AHS exige comprobante del tamaño del grupo familiar y de los ingresos de todo paciente que solicite asistencia financiera mediante el *Programa de descuentos de tarifas reducidas*.

AHS cuenta con varias opciones para suministrar comprobantes de ingresos, y le solicitamos su colaboración en proporcionar la información solicitada. Se pueden hacer excepciones limitadas cuando no sea posible suministrar comprobantes de ingresos y este formulario es uno de los métodos por medio del cual se puede eliminar ese obstáculo. En estas poco comunes circunstancias, le solicitamos que sea honrado y que colabore para completar este testimonio. Esta información se usa con el fin de determinar si reúne los requisitos para descuentos de tarifas reducidas y se contará con que cumple con los requisitos federales al ofrecerle el Programa de descuentos de tarifas reducidas. Esta información se mantendrá estrictamente confidencial, y tiene vigencia solamente hasta de un año, cuando es necesario solicitar de nuevo el Descuento de tarifas reducidas.

CERTIFICACIÓN DEL PACIENTE

Yo, _____, por medio del presente documento certifico que NO recibo ingresos de NINGUNA. Comprendo que las fuentes de ingresos incluyen, entre otras, las siguientes:

- Dinero, salario, sueldo
- Pagos con regularidad del seguro social, jubilación del ferrocarril, compensación por desempleo, compensación por accidentes laborales, pagos para veteranos de guerras, asistencia pública (como Temporary Assistance for Needy Families, o TANF; Asistencia para los necesitados o con discapacidades y Supplementary Security Income, o SSI.
- Manutención de cónyuge, manutención de hijos y asignaciones para familias militares u otra manutención con regularidad de un familiar ausente o alguien que no resida en el hogar; pensiones particulares, pensiones para empleados del gobierno (incluso pago de jubilación militar) y pagos con regularidad de seguro o rentas anuales.

Al firmar a continuación, comprendo y doy testimonio que en el momento no cuento con ninguna de las fuentes de ingresos indicadas anteriormente que proporcionen manutención para mi persona, mi familia o mi grupo familiar. Juro solemnemente que, a mi mejor saber y entender, esta información es verdadera, certera y completa y que cualquier falsificación, omisión u ocultación de hechos importantes puede dejarme sujeto a descalificación perpetua del programa de Descuento de tarifas reducidas.

También reconozco que este Testimonio personal de no recibir ingresos se utilizará para determinar si reúno los requisitos para recibir descuentos de tarifas reducidas y deberé pagar la tarifa reducida establecida adecuada en el momento del servicio para toda atención médica prestada en AHS. Comprendo que este formulario es válido solamente durante un (1) año a partir de la fecha de aprobación.

_____ _____

Firma Fecha

EXHIBIT E

SELF DECLARATION FORM (Title X)

Patient Name: _____ Acct #: _____

DOB: _____

I understand I am self-declaring income for the Family Planning Program. This program is only valid at Axis Family Planning (Title X) locations. The program is valid for one month, unless I have verified my income at Axis through other enrollment programs. The amount I will be charged will depend on the income I declare and how many people I support.

Yearly gross income (my income) _____

Yearly gross income (of all family living in household not including you) _____

{Include persons related by blood, marriage, civil union, or legal adoption}

Number (including yourself) supported by this income: _____

I understand to receive a discount for services other than for Family Planning (Title X) servces, I will need to complete a Axis SFDP Application and provide proof of income to determine eligibility.

_____ _____

Applicant Signature Date

For AHS Staff only:

FP Slide Level: _____

Dates Valid Beginning: _____ Expires: _____

HIPAA, HRSA

EXHIBIT E (continued)
SELF DECLARATION (Title X)- Spanish Version

Programa de planificación familiar con tarifas variables
FORMULARIO DE AUTODECLARACIÓN

Nombre del paciente: _____ N.° de cuenta: _____

Fecha de nacimiento (Date of Birth, DOB): _____

Entiendo que estoy declarando mis ingresos para el programa de planificación familiar. Este programa solo es válido en los centros de planificación familiar de Axis Health System (Axis) (Título X). El programa es válido por un mes, a menos que haya verificado mis ingresos en Axis a través de otros programas de inscripción. La cantidad que se me cobrará dependerá de los ingresos que declare y de cuántas personas sostenga.

Ingresos brutos anuales (mis ingresos) _____

Ingresos brutos anuales (de toda la familia que vive en el hogar sin incluirle a usted) _____
{Incluye a las personas emparentadas por sangre, matrimonio, unión civil o adopción legal}

Número de personas (incluido usted) que se benefician de estos ingresos: _____

Entiendo que para recibir un descuento por servicios que no sean de planificación familiar (Título X), tendré que completar una solicitud del programa de descuento de tarifa variable (Sliding Fee Discount Program, SFDP) de Axis y proporcionar prueba de los ingresos para determinar la elegibilidad.

_____ _____
Firma del solicitante Fecha

Solo para el personal de Axis:

Nivel de disminución de planificación familiar (Family Planning, FP): _____

Fechas válidas a partir de: _____ Expira: _____

AXISHealth System

EXHIBIT F

Sliding Fee Scale Participation Notice

Thank you for your application for the Axis Health System Sliding Fee Discount Program. Axis Health System (Axis) has determined that you qualify for the Sliding Fee Discount Program. The Program covers most services provided by Axis staff. However, some exceptions apply. The Sliding Fee Discount Program is not available for elective services or services covered by another program (auto insurance, worker's compensation, or personal injury benefits) or for already discounted programs such as DUI Services. Axis expects payment for your portion of the charges at the time of service.

Federal Poverty Guidelines may be updated by the federal government each year, and we are required to update our scale when it changes. This update may change your Sliding Fee level.

Your participation in the Sliding Fee Discount Program will expire in twelve months from the date of your application. You must reapply and provide current income documentation to determine your eligibility each year.

Patient Name: _____ Sliding Scale Level: _____

Effective Date: _____ Expiration Date: _____

Thank you,

Axis Health System

AXISHealth System

EXHIBIT F (continued)
Sliding Fee Scale Participation Notice - Spanish

Aviso de participación en la escala de tarifa variable

Gracias por su solicitud para el programa de descuento de tarifa variable (Sliding Fee Discount Program, SFDP) de Axis Health System. Axis Health System (Axis) determinó que usted califica para el programa de descuento de tarifa variable. El programa cubre la mayoría de los servicios prestados por el personal de Axis. Sin embargo, se aplican algunas excepciones. El Programa de descuento de tarifa variable no está disponible para servicios electivos o servicios cubiertos por otro programa (seguro de automóvil, compensación de trabajadores o beneficios por lesiones personales) o para programas ya descontados como los servicios de conducción bajo los efectos del alcohol (Driving Under the Influence, DUI). Axis espera el pago de su parte de los cargos en el momento del servicio.

Los lineamientos federales de pobreza pueden ser actualizados por el gobierno federal cada año y estamos obligados a actualizar nuestra escala cuando estos cambian. Esta actualización puede cambiar su nivel de tarifa variable.

Su participación en el Programa de descuento de tarifa variable expirará en doce meses a partir de la fecha de su solicitud. Deberá volver a solicitarlo y presentar la documentación de ingresos actual para determinar su elegibilidad cada año.

Nombre del paciente: _____ Nivel de la escala de tarifa variable: _____

Fecha de entrada en vigor: _____ Fecha de expiración: _____

Atentamente,

Axis Health System

EXHIBIT G
Sliding Fee Scale Denial Notice

Thank you for your application for the Axis Health System Sliding Fee Discount Program.

Axis Health System (Axis) has determined that you are DENIED for the Sliding Fee Discount Program.

The reason for the denial is:

- □ Missing information from application not provided within the 14 days allowed
- □ Income is above the threshold (200% of Federal Poverty Level)

You may reapply at any time.

Patient Name: _____ Application Date: _____

Thank you,

Axis Health System

EXHIBIT G (continued)
Sliding Fee Scale Denial Notice – Spanish version

Aviso de denegación en la escala de tarifa variable

Gracias por su solicitud para el Programa de descuento de tarifa variable de Axis Health System.

Axis Health System (Axis) determinó que usted fue DENEGADO para el Programa de descuento de tarifa variable.

El motivo de la denegación es:

- □ La información que faltaba en la solicitud no se proporcionó en el plazo permitido de 14 días
- □ Los ingresos están por encima del umbral (200% del Nivel de Pobreza Federal)

Puede volver a solicitarlo en cualquier momento.

Nombre del paciente: _____ Fecha de solicitud: _____

Atentamente,

Axis Health System

AXISHealth System	SLIDING FEE APPLICATION		Date:	3/22/2024

FAMILY SIZE

Name	AHS patient	DOB	Marital Status	Relationship

FAMILY INCOME

	Income Provided	Monthly	Annual
WEEKLY GROSS INCOME	$ -	$0.00	$0.00
BI-WEEKLY GROSS INCOME	$ -	$0.00	$0.00
SEMI-MONTHLY GROSS INCOME	$ -	$0.00	$0.00
MONTHLY GROSS INCOME	$ -	$0.00	$0.00
ANNUAL GROSS INCOME	$ -	$0.00	$0.00
Total Gross Income	$ -	$0.00	$0.00

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
	A	B	C	D	E
Number in Household	Under 100% FPL	101% - 125%	126% - 150%	151% - 175%	176% - 200%
1	$0-$15,060	$15,061-$18,825	$18,826-$22,590	$22,591-$26,355	$26,356-$30,120
2	$0-$20,440	$20,441-$25,550	$25,551-$30,660	$30,661-$35,770	$35,771-$40,880
3	$0-$25,820	$25,821-$32,275	$32,276-$38,730	$38,731-$45,185	$45,186-$51,640
4	$0-$31,200	$31,201-$39,000	$39,001-$46,800	$46,801-$54,600	$54,601-$62,400
5	$0-$36,580	$36,581-$45,725	$45,726-$54,870	$54,871-$64,015	$64,016-$73,160
6	$0-$41,960	$41,961-$52,450	$52,451-$62,940	$62,941-$73,430	$73,431-$83,920
7	$0-$47,340	$47,341-$59,175	$59,176-$71,010	$71,011-$82,845	$82,846-$94,680
8	$0-$52,720	$52,721-$65,900	$65,901-$79,080	$79,081-$92,260	$92,261-$105,440
For each additional person add	$5,380 to annual income	$ 6,725 to annual income	$8,070 to annual income	$9,415 to annual income	$10,760 to annual income
FQHC & CMHC Psych services	$15	$20.00	$25.00	$30.00	$35.00
CMHC BH	$5	$10.00	$15.00	$20.00	$25.00
Lab Services	$0	$7.00 per lab	$8.00 per lab	$9.00 per lab	$10.00 per lab
Oral Health Services	See Dental Fee Scheduled	60% discount	50% discount	40% discount	30% discount
Supplies/Devices	100% of Cost	100% of Cost	100% of Cost	100% of Cost	100% of Cost
ATU (per day)	$50.00	$75.00	$100.00	$125.00	$150.00
Pharmacy	AAC+ $4	AAC + $5	AAC + $6	AAC +$7	AAC +$8

Presumptive Status			Annualization		
☐	Estim. Income		☐	Gross income:	
	Family Size			Family Size	
Effective Date:	Begin	End	Effective Date:	Begin	End
	3/22/2024	4/5/2024		3/22/2024	3/22/2025
Slide Category:			Slide Category:		
Application Denied:					

**** DOCUMENTATION MUST BE PROVIDED PRIOR TO YOUR NEXT VISIT*****

If documentation is not provided within 2 weeks you will become responsible for 100% of all charges

I have read & understand the SFDP and agree to comply. By signing this application, I authorize AHS to confirm my income & family size, I verify that all information is true and correct. I understand that providing false information will result in all discounts being revoked.

PATIENT SIGNATURE _____ DATE _____

AHS REPRESENTATIVE _____ DATE _____

☐ Carelogic ☐ Intergy ☐ Dentrix

UPDATE 4.1.2024