Gunnison Valley Hospital Clinics Sliding Fee Philosophy and Application

It is the policy of Gunnison Valley Hospital to provide essential services regardless of the patient’s ability to pay. Gunnison Valley Hospital offers discounts based on family size and annual income.

Gunnison Valley Hospital is committed to excellence in providing high quality health care service and programs that serve the diverse needs of those living in our service area. We are dedicated to the view that medically necessary health care services should be accessible to all, regardless of age, gender, sexual orientation, cultural background, physical mobility or ability to pay. These services should be delivered in a way that maintains dignity and enhances the quality of life the persons served.

Because the services we provide are so important, we must carefully conserve the resources that make them possible. Patients who can pay for services should do so. Patients who have insurance or are entitled to government assistance should be identified and should us those resources. Those needing assistance should pay as much as they can. If we do not take every step to obtain payment from every appropriate resource, we will be left financially incapable of providing services to all those that need them.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such series. You must complete this from every 12 months or if your financial situation changes.

Proof of income is required to process your application. The documents listed below are acceptable proof of income.

|  |  |  |
| --- | --- | --- |
| W-2 Form | Unemployment award notice | Pension or retirement income |
| Income Tax returns | Social Security notice | Disability or workers’ compensation  determination letter |
| Current pay stubs | Child support and/or alimony |

**SLIDING FEE APPLICATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME | | | | |
| STREET | CITY | STATE | ZIP | PHONE |
| Have you applied for Medicaid?  If yes, please attach with application.  If no, are you willing apply for Medicaid?  If no, please explain: | | | | |

**Please list all household members, including those under age 18**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | NAME | | | DATE OF BIRTH | |
| SELF |  | | |  | |
| OTHER |  | | |  | |
| OTHER |  | | |  | |
| OTHER |  | | |  | |
| OTHER |  | | |  | |
| OTHER |  | | |  | |
| **Income Source** | | **Self** | **Other** | | **Total** |
| Gross wages, salaries, tips, etc. | |  |  | |  |
| Income from business and self-employment | |  |  | |  |
| Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement income | |  |  | |  |
| Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources | |  |  | |  |
| Total Income | |  |  | |  |

**I certify that the family size and income information shown above is correct.**

**Name: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sliding Fee Discount Schedule**

Based on the 2024 Federal Poverty Guidelines (FPG)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient Cost** | | | | | |
|  | **Slide A** 0-100% FPG | **Slide B** 101-135% FPG | **Slide C** 136-150% FPG | **Slide D** 151-200% FPG | Over 200 %FPG |
| Medical | Patient Pays $25.00 Nominal Fee\* | Patient Pays $40.00 Office Visit\* | Patient Pays $80.00 Office Visit\* | Patient Pays $100.00 Office Visit\* | No Discount |
| **Family Size** | **Annual Income** | | | | |
| 1 | $0 - $15,060 | $15,061 - $20,331 | $20,332 - $22,590 | $22,590 - $30,120 | $30,121 - up |
| 2 | $0 - $20,440 | $20,441 - $27,594 | $27,595 - $30,660 | $30,661 - $40,880 | $40,881 - up |
| 3 | $0 - $25,820 | $25,851 - $ 34,857 | $34,858 - $38,730 | $38,731 - $51,640 | $51,641 – up |
| 4 | $0 - $31,200 | $31,201 - $42,120 | $42,121 – 46,800 | $46,801 - $62,400 | $62,401 – up |
| 5 | $0 - $36,560 | $36,581 - $49,383 | $49,384 - $54,870 | $54,871 - $73,160 | $73,161 – up |
| 6 | $0 - $41,960 | $41,961 - $56,646 | $56,647 - $62,940 | $62,941 - $83,920 | $83,921 – up |
| 7 | $0 - $47,340 | $47,341 - $63,909 | $63,910 - $71,010 | $71,011 - $94,680 | $94,681 – up |
| 8 | $0 - $52,720 | $52,721 - $71,172 | $71,173 - $79,080 | $79,081 - $105,440 | $105,441 - up |

For family units with more than 8 members, add $5,380 for each additional member.

\*Cost of some supplies are NOT included in the Slide Program and additional cost will be applied. Examples include, but are not limited to: Injections, Lab work, and Durable Medical equipment.

Office Use Only

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved Discount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Verification Checklist | Yes | No |
| Identification/Address: Driver’s license, utility bill, employment ID, or other |  |  |
| Income: Prior year tax return, three most recent pay stubs, or other verification |  |  |