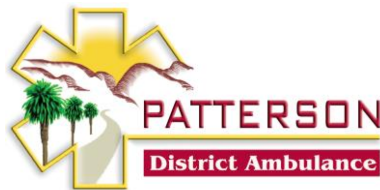

2020 SLIDING FEE DISCOUNT PROGRAM

Financial Assistance Available
The Del Puerto Health Care District (DPHCD), which operates Patterson District Ambulance and Del Puerto Health Center recognizes medical care is costly and where ever possible we want to help the people we serve. Based on your family annual income DPHCD can provide a discount to your ambulance service charges, co-pay, and co-insurance.

Sliding Fee Discount
Discounts are determined by total household gross income and number of family members. Family is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Charges will be adjusted based on the current Federal Poverty Level scale according to number of people in your family and gross income. Please include all income as noted on the enclosed application.

2020 Federal Poverty Levels	100%	200%	300%	400%
1 in family	$ 12,760	$ 25,520	$ 38,280	$ 51,040
2	$ 17,240	$ 34,480	$ 51,720	$ 68,960
3	$ 21,720	$ 43,440	$ 65,160	$ 86,880
4	$ 26,200	$ 52,400	$ 78,600	$ 104,800
5	$ 30,680	$ 61,360	$ 92,040	$ 122,720
6	$ 35,160	$ 70,320	$ 105,480	$ 140,640
7	$ 39,640	$ 79,280	$ 118,920	$ 158,560
8 in family	$ 44,120	$ 88,240	$ 132,360	$ 176,480
each additional person, add	$ 4,480	$ 8,960	$ 13,440	$ 17,920
% of Federal Poverty Level	**100%**	**200%**	**300%**	**400%**

Based on your family size & gross income on the Federal Poverty Level scale, the following discounts are allowed on the patient balance, *excluding Medi-Cal Share of Cost.*

FPL Range	Ambulance Discount	Health Center Discount
100% or less of FPL	$100 nominal fee	$15 nominal fee
101-200% of FPL	-90%	-80%
201-300% of FPL	-75%	-60%
301-400% of FPL	-60%	-40%

Application Required
To help us determine if you qualify for assistance, please complete the attached Patient Financial Declaration and return with proof of income documents.

Discount Determination Letter
Within two weeks you will receive a *Sliding Fee Determination* letter that will explain your available discount and the new balance due. Your Determination letter is valid for both Health Center and Ambulance bills.

Extra Prompt Pay Incentive
Additionally, a 30% Prompt Pay Incentive is available (deducted from your Sliding Fee Discounted total) when you pay your bill within 30 days of the date of the Determination letter. All patients can take advantage of the prompt pay discount.

If you have questions, please do not hesitate to contact us at (209) 892-8781 and ask for Sliding Fee Discount Program. We are available to assist you 8:00 AM to 5:00 PM Monday through Friday.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410, or call (800) 795-3272 (voice), or (202) 720-6382 (TDD).

How do I qualify?

To qualify for the Sliding Fee Discount, you MUST complete the application and provide the required documentation to show proof of annual income for all immediate family members living in your household. Gross income is ALL income from ALL sources before taxes. Applicants should provide a copy of any of the accepted income verification materials listed below along with a completed application to Del Puerto Health Care District Office.

Accepted Income Verification

- Prior year W-2 or 1099
- Two (2) Current Paystubs
- Letter from Employer
- Form 4506-T Request for transcript of tax return (if W2 not filed)
- Self-employed - most recent three (3) months of income and expenses for the business

The patient/responsible party must complete the Sliding Fee Discount Application in its entirety. By signing the Sliding Fee Application, you authorize Del Puerto Health Care District to verify income as disclosed on the application form. Providing false information on a Sliding Fee Application will result in Sliding Fee discounts being revoked and the full balance of the account(s) restored and payable immediately.

Effective February 2017

Contact Us

Del Puerto Health Care District

P. O. Box 187

875 E Street

Patterson, CA 95363

(209) 892-8781

www.dphealth.org

Patient Financial Assistance Program

Our Values

Compassion * Commitment * Excellence

The District's primary mission is to provide the highest quality healthcare services through the Patterson District Ambulance and Del Puerto Health Clinic while expanding the healthcare availability to the citizens of the Del Puerto Health Care District.

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Sliding Fee Discount Policy

At Del Puerto Health Care District, we never want cost to be a barrier to getting the health care you need. Our Financial Assistance program is designed to provide free or discounted care to those who have no means or limited means to pay for their medical services. We offer the Sliding Scale Fee Schedule to all income-eligible uninsured or under insured patients, based on their household's annual income.

No one will be denied access to services at Del Puerto Health Center or Patterson District Ambulance, as services are offered regardless of insurance status or ability to pay.

Financial Assistance Applications

Applications may be obtained at:

Del Puerto Health Care District Office
875 E. St
Patterson, CA 95363

Del Puerto Health Center
1700 Keystone Pacific Pkwy, Ste B
Patterson, CA 95363

www.dphealth.org

To help us determine if you qualify, please complete the Patient Financial Declaration and include all documents requested. Your application must be complete and the requested information included.

Within two weeks of submitting a complete application, you will receive a Sliding Fee Determination Letter that will explain your available discount and what new balance is due.

Extra Prompt Pay Incentive

A 30% Prompt Pay Incentive is also available (deducting additional 30% discount from the new balance on the determination letter) **when you pay your bill in full within 30 days of the date of the Determination letter**. All patients can take advantage of the prompt pay discount.

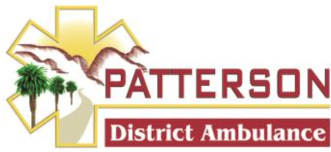
Eligibility

Discounts are determined by total family income and the number of family members. Family is defined as a group of two or more people (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered one family. Those with total family incomes at or below 100% of the poverty level will receive Health Center services a full 100% discount. Those patients with total family incomes above 100% of poverty, but at or below 200% of poverty, will be charged according to the Sliding fee Discount Schedule.

The Sliding Fee Discount Schedule is updated during the first quarter of every year with the latest Federal Poverty Guidelines.

Patterson District Ambulance patients that qualify for the maximum discount are accessed a nominal charge of $75.00 per transport. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

All alternative payment resources must be exhausted, including all third-party payment from insurance(s), Federal and State programs.



SLIDING FEE DISCOUNT APPLICATION & FINANCIAL DECLARATION

We offer the Sliding Fee Discounts to all income-eligible, uninsured, or underinsured patients based on annual Family income and size. The Sliding Fee Discount provides reduced or nominal costs on most services.

Eligibility. Patients who are unable to pay for all or part of the cost of medically necessary care, and who may have exhausted private and / or public medical coverage sources may be eligible for a Sliding Fee Discount. Prior to being considered for eligibility, patients are required to apply for public and/or private coverage, such as Medicare, Medi-Cal, for which they may be eligible. Patients shall be assisted, as needed, in determining linkage to these programs, and in applying for such coverage. Discounts cannot be applied to Medi-Cal Share of Cost.

How do I qualify? To qualify for the Sliding Fee Scale, patients must provide family income information. Gross family income will be verified by documented proof of income. Gross income is ALL income from ALL sources before taxes.

How do I get started? To begin the Sliding Fee Scale application process, simply complete this form and send it to the District Office. Patterson District Ambulance and Del Puerto Health Center accept all Medicare and Medicaid insurance plans, as well as most major insurances, but there may be a patient responsibility even after your insurance pays. Your discount is reverified each year.

No one will be denied access to services at Patterson District Ambulance or Del Puerto Health Center, as services are offered regardless of insurance status or ability to pay.

Please complete both sides of this form and fill in every blank with an answer. Please write "-0-" or "n/a" or "none" if a question does not apply. When completed, return the application along with your documented proof of income.

Family Information			
NAME OF HEAD OF FAMILY	BEST PHONE NUMBER		
RESIDENCE ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS	CITY	STATE	ZIP
EMAIL	PLACE OF EMPLOYMENT		

Do you have health insurance? Yes No	If no, have you applied for health insurance? Yes No	If yes, who in Family is covered by your Health Insurance policy?

Family Member Names	Relationship	Health Ins?	Date of Birth	Family Member Names	Relationship	Health Ins?	Date of Birth
1.SELF	Self	Yes No		5.DEPENDENT		Yes No	
2.SPOUSE	Spouse	Yes No		6.DEPENDENT		Yes No	
3.DEPENDENT		Yes No		7.DEPENDENT		Yes No	
4.DEPENDENT		Yes No		8.DEPENDENT		Yes No	

Annual Family Gross Income by Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc. (information from pay check stubs, tax returns, Form W-2 or 1099)	$	$	$	$
Income from business, self-employment, and dependents (copy of tax returns)				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the Family, and other miscellaneous sources				
Total Income	**$**	**$**	**$**	**$**

SLIDING SCALE DISCOUNT APPLICATION & FINANCIAL DECLARATION

______ People in our family are:(check all that apply)

_______ Employed

_______ Receiving Public Assistance

(Ex: Unemployment, CalWORKs, SSI etc)

_______Unemployed

_______ Retired

_______ Self-Employed

______ Please attach income documentation for each family member' income. (check all that apply)

_______ Two (2) current pay stubs

_______ IRS Form W-2 or 1099

_______ Recent federal tax return

_______ Copy of benefit letter for Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income

Questions: If you have any questions, please contact the District Office at 209-892-8781 and ask for Patient Financial Assistance or email admin@dphealth.org.

Applicant Financial Declaration:

- I hereby certify that the above information is, to the best of my knowledge, true and correct.
- I further agree to notify Patterson District Ambulance or Del Puerto Health Center of any changes in this information within ten (10) days of such change.
- I understand that I must re-qualify annually to maintain my eligibility. I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government.
- I am supplying this information and request Patterson District Ambulance and Del Puerto Health Center waive a portion or all the remaining balance (Medicare or other insurance co-pay, co-insurance, or deductible amounts due) based on my financial situation.
- I agree to be responsible for any balance remaining after the application of any discount by Patterson District Ambulance or Del Puerto Health Center.
- I agree to pay my fees promptly, to maintain the discount.

Date: ______________________________ Name (print): ______________________________________

Signature: ____

Return completed application to:

(Mail)
Del Puerto Health Care District
PO Box 187
Patterson, CA 95363

(Deliver in Person)
Patterson District Ambulance
875 E Street
Patterson, CA 95363

(Deliver in Person)
Del Puerto Health Center
1700 Keystone Pacific Pkwy, Ste B
Patterson, CA 95363

Office Use Only

Patient Name:	Date Approved:	
Approved Discount:	Approved by:	
Verify Documents Received	**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		
Insurance: Insurance Cards		