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FAMILY ASSISTANCE PROGRAM

It is the policy of Family Care Associates of Effingham, S.C. to provide essential medical services regardless of the patient's ability to pay. Assistance is offered based upon household income and size, and the Federal Register poverty level guidelines. A sliding fee schedule is used to calculate the level of assistance and is updated each year using the federal poverty guidelines*.* ***Once approved, the discount will be honored for six months, after which time the patient must reapply.*** Household size is defined as all individuals living in a single residence, including students at college or prep school. Financial information is required for everyone determined to be part of the household. Please complete and return the following Family Assistance Application; you will be notified of your eligibility once the application is processed.

A completed application including required documentation of the home address, household income, copies of current tax return, insurance coverage and any student financial forms (such as 1098 T-forms, etc.) must be on file and approved by the billing department before assistance will be granted*.* If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid is required.

Proof of Income (if employed) is required. Please provide your most current tax returns, with W2(s) and three recent pay stubs.

Proof of Income (if unemployed) is required. Examples: current tax returns, public assistance check stub, social security check stub, or letter of award from Medicaid or SSI. If applicant is a college student, submissions of 1098 T-forms are also required.

Proof of Address is required. This includes driver's license or State ID and an envelope addressed to the patient (such as a utility bill, phone bill, etc.) Proof of Address is required (immigrants) form 1551, form 194.

Patients who decline to offer this information are ineligible for assistance.

Family Care Associates write-off/assistance amount is based on the Federal Register poverty level guidelines. The maximum amount written off by Family Care Associates will be up to 100% when meeting the Federal Poverty Level guidelines of 150%. Once an applicant(s) is approved for Family Assistance, Family Care Associates will adjust current balances due, and any charges incurred over the six month approval period based on the date of application approval.

Patient account balances are adjusted based on the following guidelines:

- Office/Hospital visits are adjusted according to the approved discount rate based on billed fees less any applicable insurance payments.
    - The minimum fee for each office/hospital visit is $15.00 (poverty level 150-200%)
- Additional charges (such as labs or procedures) are discounted based on billed fee less any applicable insurance payments. Adjustment is based on the following:
    - Poverty level 150-200% - 90% discount
    - Poverty levels 225-400% - adjusted based on approved discount rate

FAMILY ASSISTANCE APPLICATION

Guarantor Information: (*Person responsible for paying the bill / applying for application*)

Name: Last	First		MI
Address: Street	City	State	Zip Code
Date of Birth:	Primary Care Physician (PCP)		
Telephone Number: Home/Cell Work		DOB	SSN:

Household Size Information:

Total number of people living in Household: ________ .

Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:

Please fill out reverse side for household earnings

Household Earnings:

Household Members & SSN	Age	Source of Income / Employer Name	Monthly Gross Wages (including tips and salaries)

Additional Income:

Source of Additional Income	Self	Spouse	Dependents/ Relatives in Household	Totals
Soc. Security, pension, annuity, veterans benefits				
Alimony, child support , military family allotments				
Rent, interest, dividend, and other income				

NOTE: *Include income from all persons in household and income from all sources, including gross wages (include 1040, 1040A or 1040EZ) , tips, social security, disability, pensions, annuities, veterans payments, net business, self-employment or farm (include applicable tax schedules), alimony, child support, military, unemployment compensation (include length of time, expected return date), Worker's Compensation (include length of time, expected return date), Medicaid, public assistance (including food stamps, circuit breaker) and for other income indicate source.*

Updated: 11-20-2014

Required Information:
(Please include ALL listed documents)

- ☐ **Copy of Previous Year's Tax Return**
  - ☐ **Attached**
  - ☐ **Not Attached, Reason:** ____________________
- ☐ **Proof of Income**
  - ☐ W2 Form
  - ☐ 3 Most Recent Pay Stubs
- ☐ **Proof of Address**
  - ☐ Driver License or State ID of each member in household if applicable
  - ☐ Envelope Addressed to Patient at Current Address
    (This can include utility bill, phone bill, etc. – must be postage stamped to be valid)

Family Assistance/Sliding Fee Application

The discount will apply to all services received at our office, but does not include services which are performed from outside facilities, such as reference laboratory, hospital, x-ray, etc.

I certify that the household size and income information shown on the previous page is correct. Copies of tax returns, pay stubs, and other information verifying income will be required before Family Assistance is granted.

Name (Print)   Signature   Date

For Office Use Only

Total Household Income: ____________________

Insured / Uninsured

Size of Family: ____________________

Qualifies for: ____________________

Approved By: ____________________ Date: ____________________

Updated 9-22-2016
Updated 6-23-2016
Updated 4-12-2016
Updated 11-20-2014