



HealthNet of Rock County Sliding Fee Scale Application

I will need help with completing this application: YES NO

HealthNet will provide essential services regardless of the ability to pay. HealthNet offers discounts based on family size and annual income. Please complete the following information to determine if you or members of your family are eligible for a discount.

The discount will apply to services received at the Dental or Behavioral Health Clinics, **but not the services provided in Medical, or outside referred services to specialists for care. You must complete this form every 12 months or if your financial situation changes.**

Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

➤ Emergency Contact: _____ #: _____ Relationship: _____

List all household members, including those under age 18.	NAME	DATE OF BIRTH
SELF		/ /
OTHER		/ /
OTHER		/ /
OTHER		/ /

SOURCE	SELF	OTHER	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income business/self-employment- self- declaration- Patients unable to provide written verification may provide a signed statement of income.				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest; dividends; royalties; income from rental properties, trusts; alimony; child support; assistance from outside the household; other sources				
TOTAL INCOME				

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

Name (Printed): _____

Name (Signature/Patient Witness): _____ Date: _____

HRSA Sliding Fee Scale (SFS) Discount Schedule

Based on 2023 Federal Poverty Guidelines [Poverty Guidelines | ASPE \(hhs.gov\)](https://www.hhs.gov/ipo/2023/01/2023-federal-poverty-guidelines)

POVERTY LEVEL	ANNUAL INCOME					
	At or Below 100% (Nominal \$10 suggested)	101-125% (SF Flat Rate Below)	126-150% (SF Flat Rate Below)	151-175% (SF Flat Rate Below)	176-200% (SF Flat Rate Below)	201-250% (SF Flat Rate Below)
FAMILY SIZE	Category A	Category B	Category C	Category D	Category E	Category F
1	\$0 - \$14,580	\$14,581 - \$18,225	\$18,226 - \$21,870	\$21,871 - \$25,515	\$25,516 - \$29,160	\$29,161 - \$36,450
2	\$0 - \$19,720	\$19,721 - \$24,650	\$24,651 - \$29,580	\$29,581 - \$34,510	\$34,511 - \$39,440	\$39,441 - \$49,300
3	\$0 - \$24,860	\$24,861 - \$31,075	\$31,076 - \$37,290	\$37,291 - \$43,505	\$43,506 - \$49,720	\$49,721 - \$62,150
4	\$0 - \$30,000	\$30,001 - \$37,500	\$37,501 - \$45,000	\$45,001 - \$52,500	\$52,501 - \$60,000	\$60,001 - \$75,000
5	\$0 - \$35,140	\$35,141 - \$43,925	\$43,926 - \$52,710	\$52,711 - \$61,495	\$61,496 - \$70,280	\$70,281 - \$87,850
6	\$0 - \$40,280	\$40,281 - \$50,350	\$50,351 - \$60,420	\$60,421 - \$70,490	\$70,491 - \$80,560	\$80,561 - \$100,700
7	\$0 - \$45,420	\$45,421 - \$56,775	\$56,776 - \$68,130	\$68,131 - \$79,485	\$79,486 - \$90,840	\$90,841 - \$113,550
8	\$0 - \$50,560	\$50,561 - \$63,200	\$63,201 - \$75,840	\$75,841 - \$88,480	\$88,481 - \$101,120	\$101,121 - \$126,400
For family units with more than 8 persons, add \$4,720 for each additional member						
DENTAL AND BEHAVIORAL HEALTH SLIDING FEES						
FLAT FEE \$	\$10*	\$30	\$35	\$40	\$45	\$50

*For individuals at or below 100 % of the FPL, it is strongly encouraged that staff facilitate applications for BadgerCare or ask patients to pay a \$10 nominal fee. However, if neither can happen before the time of service, a patient will not be denied services.

ADDITIONAL DENTAL EXTRA SERVICE PROCEDURES

Crown: The crowns that HealthNet recommends to do are porcelain zirconia crowns that are not covered by Medicaid insurance. Therefore, if a lab made crown at HealthNet is advised, the patient is responsible for the fee assigned by HealthNet. An appointment will be made once the fee is paid in full.

Denture/partial/other lab related items: If the patient has insurance, and the type of denture/partial/lab item is covered by insurance, it will be preauthorized. If it is a covered denture/partial/lab item, the patient is responsible for the copays assigned by insurance. If the denture/partial/lab item is denied by insurance or is not a covered code, the patient is responsible for the fee assigned by HealthNet. An appointment will be made once the fee is paid in full.

Nitrous Oxide: For ages 0 to 17, there will be no fee assigned regardless of insurance status. For ages 0-17, if there is insurance, a preauthorization will be sent. If the nitrous is denied by insurance, there will be no additional charge. If the patient is 18 and over and has insurance, and nitrous is covered by insurance, it will be preauthorized. If the nitrous is not covered or is denied by insurance, the patient is responsible for the fee assigned by HealthNet which is \$30. For those 18 and over and uninsured, the fee will be \$30.

The patient will be presented with a treatment plan sheet with the specific lab service procedure and fee associated to agree upon process and payment terms. Cash, debit and credit cards will be accepted- no checks over \$100 will be accepted. An appointment will be made once the fee is paid in full.



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OFFICE USE ONLY ----- VERIFICATION CHECKLIST

VERIFICATION CHECKLIST- Must provide one item in each section	YES	NO
IDENTIFICATION: Driver's License, utility bill, employment ID, passport, other _____		
ROCK COUNTY RESIDENCY: Lease/mortgage papers/handwritten paper from landlord, piece of mail with patient's name (utility bill, bank statement, phone bill), other _____		
INCOME VERIFICATION: Prior year tax return (W-2), two most recent pay stubs, letter from employer, form 4506-T. If self-employed necessary information, self-declaration, other _____		

APPLICATION STATUS/RESULTS

Patient Name: _____

Date: _____

FPL % Range: _____ Category: A B C D E F

Approved: **YES NO**

If NO, reason for denial: _____

HealthNet Representative: _____

Application Assistance Provided by: _____