# 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:______________

HealthNet OF ROCK COUNTY

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**HRSA Sliding Fee (SF) Discount Schedule**

**Based on 2022 Federal Poverty Guidelines** **www.home.mycoverageplan.com**

| POVERTY LEVEL | ANNUAL INCOME | | | | | |
|---|---|---|---|---|---|---|
| | At or Below 100% (Nominal $10 suggested) | 101-125% (SF Flat Rate Below) | 134-150% (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 - $13,590 | $13,591 - $16,988 | $18,076 - $20,385 | $20,386 - $23,783 | $23,784 - $27,180 | $27,181 - $33,975 |
| 2 | $0 - $18,310 | $18,311 - $22,888 | $24,353 - $27,465 | $27,466 - $32,043 | $32,044 - $36,620 | $36,621 - $45,775 |
| 3 | $0 - $23,030 | $23,031 - $28,788 | $30,631 - $34,545 | $34,546 - $40,303 | $40,304 - $46,060 | $46,061 - $57,575 |
| 4 | $0 - $27,750 | $27,751 - $34,688 | $36,909 - $41,625 | $41,626 - $48,563 | $48,564 - $55,500 | $55,501 - $69,375 |
| 5 | $0 - $32,470 | $32,471 - $40,588 | $43,186 - $48,705 | $48,706 - $56,823 | $56,824 - $64,940 | $64,941 - $81,175 |
| 6 | $0 - $37,190 | $37,191 - $46,488 | $49,464 - $55,785 | $55,786 - $65,083 | $65,084 - $74,380 | $74,381 - $92,975 |
| 7 | $0 - $41,910 | $41,911 - $52,388 | $55,741 - $62,865 | $62,866 - $73,343 | $73,344 - $83,820 | $83,821 - $104,775 |
| 8 | $0 - $46,630 | $46,631 - $58,288 | $62,019 - $69,945 | $69,946 - $81,603 | $81,604 - $93,260 | $93,261 - $116,575 |
| For family units with more than 8 persons, add $4,720 for each additional member | | | | | | |
| **BEHAVIORAL HEALTH PRESCRIBER VISIT SLIDING FEE** | | | | | | |
| **PRESCRIBER $** | $10* | $35 | $45 | $50 | $55 | $60 |
| **BEHAVIORAL HEALTH THERAPY VISIT SLIDING FEE** | | | | | | |
| **THERAPY $** | $10* | $30 | $40 | $50 | $50 | $50 |
| **DENTAL PREVENTIVE CARE VISIT SLIDING FEE** | | | | | | |
| **PREVENTIVE $** | $10* | $30 | $35 | $35 | $40 | $40 |
| **DENTAL RESTORATIVE/EMERGENCY VISIT SLIDING FEE** | | | | | | |
| **RESTORATIVE $** | $10* | $30 | $40 | $50 | $50 | $50 |

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

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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:__________________________________________