Patient MRN: _____

Sliding Fee Discount Application

It is the policy of QuickVisit Urgent Care to provide essential services regardless of the patient's ability to pay. QuickVisit Urgent Care offers discounts based on family size and annual income through the Sliding Fee Discount Program (SFDP). Please review, complete, and sign the following information to determine if you or members of your family are eligible for a discount.

General Policy Information:

- 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 services.
- Applicants must provide two active identification documents, which may include: state issued driver's license, state issued identification card, birth certificate (if born in the U.S.A.), marriage license (if name verification needed), employment identification badge, Iowa Medicaid identification card, utility bill, voter's identification card, valid passport, and/or Alien Registration Card (commonly known as a "green card").
- A patient eligibility for the SFDP is based solely on the basis of the patient's ability to pay and family/household size and does not discriminate on the basis of age, gender, race, creed, sexual orientation, disability, national origin, or legal presence/status. Documentation of income and family/household size are the sole factors considered in determining whether patients are eligible for the SFDP.
- If a patient/family/household chooses not to provide information required for determining income and family/household size the patient is ineligible for the SFDP.
- According to the Census Bureau a 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. In other words, a "household" would include people you would include on your taxes.
- The Sliding Fee Discount Program may be applied to eligible patients with third party insurance coverage unless the third party insurance contract prohibits the application of the Sliding Fee Discount Program.
- Providing false information or information subsequently determined to be false on a SFDP application will result in all SFDP discounts being revoked and the full balance of the account(s) restored and payable immediately.
- Completed application and proof of income information must be provided to QuickVisit Urgent Care within 30 days of the initial visit. The Sliding Fee Discount will start on the day of approval. Re-certification for the discount must be completed every 6 months.

By signing, I certify that I have read and understand the above information.

Name (Please Print): _____

Signature: _____ Date: _____

Patient MRN: _____

Patient Information:

Name: _____ DOB: _____

Email: _____

Primary Phone: _____ Secondary Phone: _____

Health Insurance: _____ ☐N/A - Uninsured

Member ID: _____ Group Number: _____

Address: _____

Income Information:

Are you currently employed? ☐Yes ☐No

Is your spouse/partner currently employed? ☐Yes ☐No ☐N/A

Are any other family members who live with you employed? ☐Yes ☐No ☐N/A

If you have no sources of income, please explain how you obtain basic life essentials, food, and shelter. _____

_____

_____

_____

Please list all household members, including those under the age of 18. Note: See definition of " "household" on page 1. You must provide an Income Tax Return from the most recent filing year to validate your household. If you did not file taxes, address verification for all members of the household age 6 and older is required. You must also provide Proof of Residency by providing a copy of a lease/rental agreement OR a current utility bill (gas, water, electric) from within the last 30 days.

Name	DOB	Relationship to Patient/Applicant
		Self

Patient MRN: _____

Please list all income from each household member.

Source of Income	Person #1 Name:	Person #2 Name:	Person #3 Name:	Person #4 Name:
Employment	$	$	$	$
Self- Employment	$	$	$	$
Unemployment Benefits	$	$	$	$
Retirement or Pension	$	$	$	$
Social Security	$	$	$	$
Disability	$	$	$	$
Rental or Royalty Income	$	$	$	$
Other Income	$	$	$	$
OR Attach Zero Income Form	☐ No Income	☐ No Income	☐ No Income	☐ No Income
Documentation of Income Included with Every Listed Income Source?	☐ All documents are attached	☐ All documents are attached	☐ All documents are attached	☐ All documents are attached

Total Household Income: _____

You must show proof of identification, income, household, and residency by providing all of the following:

1. Photo ID
2. Prior year W-2 (OR Form 4506-T if W-2 not filed)
3. Three most recent pay stubs (must span 4 weeks)
4. Income Tax Return from Prior Year (OR Address Verification for all household members)
5. Proof of residency (utility bill, etc.)

**Self-employed individuals will be required to submit the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program.*

I certify that the family size and income information shown above is correct and truthful. I understand that falsification of documentation could result in denial of the Sliding Fee Discount and could result in being billed in full fee schedule amounts. I agree to notify QuickVisit Urgent Care should my income or household information change. I understand that in evaluating a patient eligibility for the Sliding Fee Discount Program in compliance with federal regulations, it is necessary to ask personal questions about the patient and their family/household and may be asked to provide additional documentation.

Name (Please Print): _____

Signature: _____ Date: _____

Please email your completed application, identification, verification of income, verification of household, and proof of residency to SlidingScale@QuickVisitUC.com. Failure to provide full and complete documentation may result in denial from the program.

Patient MRN: _____

For Office Use Only

Patient Name: _____ Patient MRN: _____

Based on the Sliding Fee Discount Application, all supporting documentation provided, and the below sliding scale fee, the above-named individual is:

☐ Approved ☐ Denied

Approved By: _____

Approved Discount: _____% Nominal Fee: $_____ Total to Pay: $_____

Approval Date Range: _____ - _____

Persons in Household	< 100%	101-140%	141-160%	161-180%	181-200%	201% +
1	$15,960	$15,961 $22,344	$22,345 $25,536	$25,537 $28,728	$28,729 $31,920	$31,921
2	$21,640	$21,641 $30,296	$30,297 $34,624	$34,625 $38,952	$38,953 $43,280	$43,280
3	$27,320	$27,321 $38,248	$38,249 $43,712	$43,713 $49,176	$49,177 $54,640	$54,641
4	$33,000	$33,001 $46,200	$46,201 $52,800	$52,801 $59,400	$59,401 $66,000	$66,001
5	$38,680	$38,681 $54,152	$54,152 $61,888	$61,889 $69,624	$69,625 $77,360	$77,361
6	$44,360	$44,361 $62,104	$62,105 $70,976	$70,977 $79,848	$79,849 $88,720	$88,721
7	$50,040	$50,041 $70,056	$70,057 $80,064	$80,065 $90,072	$90,073 $100,080	$100,081
8	$55,720	$55,721 $78,008	$78,009 $89,152	$89,153 $100,296	$100,297 $111,440	$111,441
Discount Amount	**100%**	**80%**	**60%**	**40%**	**20%**	**0%**
Nominal Fee	$20	$20	$20	$20	$20	N/A
Total to Pay	$20	$51.80	$83.60	$115.40	$147.20	$159