VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

It is the policy of Ventura County Health Care Agency to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at the center but not those services which are purchased from outside our clinics, such as specialized diagnostic testing, X-Rays, CT Scans, MRIs, pharmaceuticals, interpretation by a consulting radiologist, dental lab work and similar services. In the hope that your economic health improves, discounts apply only to current, not future services. This form must be completed annually and/or if there are any changes. Please inquire at the front desk if you have questions.

Patient Name: ____

Date of Birth: ______________________________ Phone Number: ______________________________

The data gathered on this form will only be used so that we can better meet your medical, behavioral health and dental needs. This information will not be used to withhold or deny services to you. Ventura County HCA will only determine eligibility based upon your family size and income.

1. Are you covered under Medi-Cal, Medi-Care or any other insurance? Yes No
2. If insured, what is your annual deductible? $ ______________

How many related people live in your household? This includes yourself, spouse, and dependents under the age of 18. ____________

Income Verification

Include income from all related persons in household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans' payments, net business or self-employment income, alimony, child support, military payments, unemployment, public aid and other.

<table>
<tr><th>Source</th><th>Estimated Weekly Income</th><th>Estimated Biweekly Income</th><th>Estimated Monthly Income</th><th>Estimated Annual Income</th><th>Office Use Only Section</th></tr>
<tr><td>Annual Conv. Factor</td><td>X 52</td><td>X 26</td><td>X 12</td><td></td><td rowspan="10">I received the following income verification documents (Check all that apply /copies to be scanned with application):
Recent Pay Stub: ☐
W2: ☐
Tax Return: ☐
Benefit Statement (unemployment, workers comp, Social Security): ☐
Bank Statement: ☐
Employer Letter: ☐
Other: ____________________</td></tr>
<tr><td>Wages</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Disability</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Social Security</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Unemployment</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Workers Comp</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Family Support</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Rental Income</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Other Income</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Total Income:</td><td></td><td></td><td></td><td></td></tr>
</table>

PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the family size and income information shown above is correct, and I will update the health center in the event there is a change in my income or insurance status. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

I acknowledge that I am financially responsible for all or a portion of my care, and I will be asked to provide payment at the time of service. I authorize the release of any information necessary to establish my family's eligibility for discounted services, and I give my consent to release my information to affiliated third parties involved with the discount program.

Patient Signature: ____ Date: _________________________

Office Use Only:

Medical Record Number: ________________________________
Program for which the Patient Qualifies: ________________________________
Expiration/Renewal Date: ________________________________
Sliding Fee: ***1*** ***2*** ***3*** ***4*** ***5***

Employee Certification Statement
I certify that I asked the applicant about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant and reflects the information reported to me.

Staff Signature: ____ Date: __________________________

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SELF-DECLARATION OF INCOME

PATIENT'S NAME: ________________________________ **DATE OF BIRTH:** _____________

Please check and complete the following information:

I, _______________________________________, declare that I have been working and receiving cash payments in the amount of $ ___________ per (check one) ____ day; ____ week;

____ bi-weekly; ____ monthly.

Name of Employer: ____

____________ I declare that I have no check stubs or other documentation to prove my earnings.

____________ I declare that I am unemployed and do not currently have any income.

I understand that any falsification or failure to report any income or changes in income may result in my being ineligible for the sliding fee scale adjustment to my charges for services.

SIGNATURE: _____________________________________ DATE: _______________________

For staff use only

Witness:

I witness that this patient has no documentation for the proof of income:

Print Name: ________________________________ Date: ____________________________

Signature of Witness ____

FQHC SLIDING FEE DISCOUNT PROGRAMS

Family Size	Sliding Fee Program #1 0% - 100% FPL	Sliding Fee Program #2 100.01% - 138% FPL	Sliding Fee Program #3 138.01% - 150% FPL	Sliding Fee Program #4 150.01% - 200% FPL	Full Charge Program #5 Above 200%
1	$14,580	$20,120	$21,870	$29,160	$29,160+
2	$19,720	$27,214	$29,580	$39,440	$39,440+
3	$24,860	$34,307	$37,290	$49,720	$49,720+
4	$30,000	$41,400	$45,000	$60,000	$60,000+
5	$35,140	$48,493	$52,710	$70,280	$70,280+
6	$40,280	$55,586	$60,420	$80,560	$80,560+
7	$4,520	$62,680	$68,130	$90,840	$90,840+
8	$50,560	$69,773	$75,840	$101,120	$101,120+
For each additional person add $5,140					
Fees	**Nominal Fees**	**Discounted Fees**	**Discounted Fees**	**Discounted Fees**	**Full Charge**
Schedule A *	$10.00	$15.00	$20.00	$25.00	**Full Charge***
Schedule B *	$15.00	$20.00	$25.00	$30.00	**Full Charge***
Schedule C *	$6.00	$8.00	$9.00	$10.00	**Full Charge***
Schedule D *	$10.00	$20.00	$30.00	$40.00	**Full Charge***
Schedule E *	$20.00	$40.00	$50.00	$80.00	**Full Charge***
Schedule F *	$20.00	$40.00	$60.00	$80.00	**Full Charge***
Schedule G *	$0.00	$0.00	$0.00	$0.00	**Full Charge***

Based on 2023 Federal Poverty Guidelines: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

*See Schedule of Services

**Patient may qualify for the VCMS Self-Pay Discount Program

Ambulatory Care
Services Schedule

Schedule A

	General primary medical care including medically-indicated point-of-care testing, preventive vaccines, stocked medication, X-ray, and health education at point of care *
	Well child services *
	Gynecological care *
	Prenatal including NST *
	Post partum care *
	Urgent care *
	Mental health therapy visits *

Schedule B

	Dietitian visits
	Optometric exam
	Physical therapy
	Pain management
	Podiatry
	Nephrology
	Urology
	Neurology
	Orthopedics (including casts, splints)
	Rheumatology
	Bariatrics (non-procedural services)
	Ultrasounds
	Psychiatry

Schedule C

	Complete blood count
	Basic metabolic panel
	Lipid panel
	Liver panel
	Thyroid stimulating hormone
	HbA1C
	Urinalysis
	Pregnancy test (blood)
	STD test
	Hepatitis test
	HIV Test
	Immunizations
	Pap smear
	Prenatal labs

Schedule D

	Preventive dental services
	Dental x-rays
	Dental fillings
	Dental sealants
	Peridontal scaling and root planing, per quadrant

Schedule E

	Other dental services
	Joint injections
	Colposcopy
	Botox services
	Other services and simple procedures 29 min or less

Schedule F

	Vasectomy
	Circumcision
	Insertion or removal of IUD
	Nexplanon insertion or removal
	Toenail removal
	Other services and procedures 30 min or more

Schedule G

	Blood pressure checks not included in Schedule A
	Retinal screening not included in Schedule A
	X-ray not included in Schedule A
	Nurse visits not included in Schedule A
	In-clinic labs not included in Schedule A

* These encounters includes point of care testing, x-ray, blood pressure checks, nurse encounters, and retinal screening.