DENTAL CLINIC
Sliding Discount Fee Schedule Information & Application

What is the Sliding Discount Scale Fee Schedule?

The Sliding Discount Scale Fee Schedule (SDS) is part of a federal program (Federally Qualified Health Centers - FQHC) that allows Aviva Health to discount normal charges for dental visits for our qualifying patients based on household size and household income. **(Note that Lab Fees are not eligible for this discount).** In order to qualify for the program, patients must provide proof of income below 200% of the current federal poverty level (see chart).

HOUSEHOLD SIZE	Sliding Discount Scale MONTHLY INCOME LEVEL (UPDATED AS OF March 29, 2022)					Private Pay
1	Up to: $1,133	Up to: $1,506	Up to: $1,982	Up to: $2,265		Over $2,266
2	$1,526	$2,029	$2,670	$3,052		$3,053
3	$1,920	$2,554	$3,360	$3,840		$3,841
4	$2,313	$3,076	$4,047	$4,625		$4,626
5	$2,706	$3,599	$4,735	$5,412		$5,413
6	$3,100	$4,123	$5,425	$6,200		$6,201
7	$3,493	$4,645	$6,112	$6,985		$6,986
8	$3,886	$5,168	$6,800	$7,772		$7,773
Sliding Scale Patient Responsibility	A = 10%	B = 20%	C = 40%	D = 70%		* Full Fee *

The Sliding Discount Fee is available to all patients. If you have insurance coverage, Aviva Health is required by the FQHC program to bill your insurance for your dental visit charges. You may be responsible for insurance co-pay in this situation. You may submit an application for the Sliding Discount Scale Fee to apply to the patient responsibility portion of the charges.

Depending on household size and household income, dental patients are assigned a responsibility tier of 10%, 20%, 40%, 70% or 100% of the fees normally charged for a dental visit.

Patients that qualify for the discounted fees are expected to pay the discounted fee at the time of service unless other arrangements have been made.

How do I know if I qualify for the Sliding Discount Scale Fee?

By federal law, qualification for the Sliding Discount Scale is based on two factors, household size and income. In order to determine whether you will qualify for a discounted fee, follow the directions below:

1. **Find the row on the attached chart that lists the number of individuals in your household.** This number should include yourself, your spouse/partner, and children - If you are providing *more than 50% financial support for other related individuals who reside full-time in your household* you may count them as well (grandchildren, grandparents, nieces/nephews, aunts/uncles, etc.)

2. **Next, find your gross household income range (before taxes) on the attached chart, either by month, week, or annual basis.** *You must include the income of all adult members (18 years or older) of the household* – if an adult member of your household is not currently receiving any form of income, you will be asked to sign a formal statement as part of the application declaring zero income for that individual.

The column that matches the number of qualifying household individuals and gross income will show the discount for which you qualify and the nominal fee charged for that discount category at the bottom of the column.

Note: If you are currently eligible for and receiving benefits from Oregon's Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP), you automatically qualify for a 30% Discount upon completion of the SDS application. If you are eligible for a greater discount based on household size and household income, you will need to include proof of income as detailed below. Be sure to bring a copy of your TANF and/or SNAP benefit letter when you submit your SDS application as you may qualify for a greater discount.

How often do I have to re-apply to continue receiving the Sliding Discount Scale Fee?

Once approved by Aviva Health, your SDS eligibility is good for up to one year from the date of application, based on source of income. Information must be updated if your household size or household income changes. At a minimum, a new application must be completed every 12 months in order to continue receiving the Discounted Fee.

Please note that without proof of income, Aviva Health cannot, by federal law, allow patients to claim the Discounted Fee. We are required to have on file proof that we verify income for each SDS applicant who receives the Discounted Fee and are subject to federal audits that check for compliance with this requirement. If we are unable to verify income within 30 days of your application, you will be responsible for the full fee amount of your dental visit. If you have any questions about the Sliding Discount Scale Fee or other assistance programs, please ask to speak with our receptionists.

How do I sign up for the Sliding Discount Fee?

1. First, complete the Sliding Discount Scale Fee Application included with this informational packet. Instructions are included on the application, and please feel free to ask a receptionist if you have any questions regarding the application.

2. Next, you will need to provide proof of income, including the following if applicable:
   - W-2 Wages, tips
   - Help from relatives and non-relatives
   - Business Profits
   - Veteran's Benefits
   - Sick Pay
   - Social Security Income
   - Worker's Compensation Income
   - Pension/Retirement Income
   - Alimony Received
   - Child Support Received
   - Unemployment Compensation
   - Disability or Supplemental Security Income (SSI)
   - Rents Received (Net)
   - Royalties Received
   - Investment Income (including rent, interest, dividends, or annuity payments received)
   - TANF or SNAP Eligibility Letter
   - Financial Award Letter AND School-Provided Budget (Only net remaining amount - the 'refund' you receive from the school - will be considered)
   - Deductions commonly taken out of income before the client receives it. These include:
     - Federal, state and local taxes
     - Social Security payments
     - Deductions for savings bonds, other savings plans, or union dues

3. Attach proof of income – Examples of acceptable proof listed below (copies are acceptable):
   - W-2 Wage Statement for the prior year
   - 1099 Statements for the prior year
   - Last 30 days of Paycheck stubs
   - Income Tax Return for the most recent year
     - **IMPORTANT: IF USING INCOME TAX RETURN, YOU MUST INCLUDE THE ENTIRE RETURN WITH ALL WORKSHEETS ATTACHED**
   - Unemployment Verification (Benefit Statement)
   - Court Documents (Alimony and/or Child Support)
   - Agency Letter Stating Benefit Level (for TANF or SNAP recipients)
   - Benefit Letter (SSI and Social Security recipients)

4. Submit your application with attached proof to the receptionist at Aviva Health or mail to:

   Aviva Health
   Attn: Patient Accounting
   150 NE Kenneth Ford Drive
   Roseburg, OR 97470

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Sliding Discount Fee Schedule Application

It is the policy of Aviva Health to provide patient-centered primary care regardless of the patient's ability to pay. Discounts are offered based upon household income and the number of persons living in the household. A sliding fee schedule is used to calculate the basic discount and is updated each year using federal poverty guidelines. Once approved, and based on your source of income, the discount will be honored for up to one year from the date of application, after which the patient must reapply.

A completed application including verification of income must be on file and approved by the business office before a discount will be applied. If the applicant is eligible for other assistance programs, such as the Oregon Health Plan, the finance office will assist the applicant with applying for these in addition to the Sliding Discount Fee Schedule offered by Aviva Health.

Please complete the following information:

I. Patient Information

Patient Name:	Last	First	MI
Address: Street		City	State / Zip Code
Date of Birth:	Primary Care Physician (PCP)		

II. Guarantor Information

Name:	Last	First	MI
Address:	Street	City	State / Zip Code
Telephone Number:	Home/Cell / Work	Date of Birth	Social Security Number

III. Household Size Information – List all Individuals in the household *

1.Name/Relationship	Date/Birth	Age	4.Name/Relationship	Date/Birth	Age
2.Name/Relationship	Date/Birth	Age	5.Name/Relationship	Date/Birth	Age
3.Name/Relationship	Date/Birth	Age	6.Name/Relationship	Date/Birth	Age

**** Please attach a separate sheet with additional dependents if you need more room***

(For Office Use Only) Sliding discount rate: A B C D F Z

Self-Declared_____ Applied for OHP Y N Date_____

Application date:_____Expiration Date:_____Mercy Slide _____

Total Mo. Income:_____# of Household Members_____

Staff member completing form:_____Date: _____

IV. Household Earnings Information – Please indicate ALL people living in your household who contribute financially, including applicant. Include anyone at least 18 years of age or older who reside in the household and contribute to the basic living expenses of the household (including yourself.) Income includes gross (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, pensions and/or IRA distribution income or other retirement income, etc. (see instructions for complete list.)

Household Members	D/Birth	Age	Source of Income or Employer	Monthly Gross Income
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Total Monthly Income $_____

VI.Additional Information

Are you currently receiving Food Stamps (SNAP)? YES NO

Are you currently receiving TANF? YES NO

If you checked yes to one of the above boxes and wish to qualify for the 30% discount only, you must attach your letter of eligibility.

VII. Required Information – Must be attached to this application (SEE INFORMATION FOR MORE DETAIL)

Please check that you have attached the following documentation – Aviva Health CANNOT, by federal statue, provide you with a discounted fee without proof of qualifying income:

☐ **Copy of Previous Year's Tax Return** ☐ **Copy of Paystubs Showing Income YTD**

☐ **SNAP or TANF Eligibility Letter* (if checked)** ☐ **Other**

*Providing a current eligibility letter for SNAP or TANF will automatically qualify applicant for the 30% Discount. If applicant is eligible for a greater discount based on income and household size and provides proof of income in addition to a SNAP or TANF eligibility letter, the greater discount will be applied.

To the best of my knowledge, the above information is accurate and complete for all members of my household. (Please sign, date, and print your name) _____

_____.

This application process was discussed with the patient by:
(Staff – please sign, date, and print your name) _____
_____

AVIVA HEALTH
AUTHORIZATION TO RELEASE FINANCIAL INFORMATION

I understand that once approved, this Application for Reduced Charges may qualify the members of my household for charity care through Mercy Medical Center.

☐ I authorize representatives of Aviva Health to release any information, including proof of income, to Mercy Medical Center representatives for the purpose of verifying charity care eligibility.

Signature:_____ Date:_____

(Responsible Party)

OR

☐ I waive the opportunity to be considered for charity care through Mercy Medical Center at this time.

Signature:_____ Date:_____

(Responsible Party)

Signature:_____ Date:_____

(Aviva Health staff member assisting with completion of this form)