GPW Health Center

Dedicated to Your Health!

Discount Fee Program

The **Discount Fee Program (DFP)** makes sure patients have access to all Center services (medical, pediatric, OB-GYN, dental and/or behavioral health) regardless of their ability to pay. To determine if the patient qualifies for discounted fees, **it is necessary to ask personal questions about the patient and their family/household to meet federal regulations**. The answers provided by the patient and their family/household will be kept on file and in strict confidence.

Only family/household income and size are used to determine if you qualify for discounted fees. Age, sex, race, creed, sexual orientation, disability, national origin, or legal presence/status are not considered. Government issued photo identification (identification card, driver's license, passport) is required to prove who you are.

How Long is DFP Application Valid? – This application only lasts 12 months after date approved. The family/household must re-apply at least once a year. The family/household must provide updated information if: (1) the family/household financial situation changes significantly (e.g., lose employment, gained employment, change in household, etc.) and/or receives insurance coverage after approval date but before 12 months has passed; or (2) more than one year has passed since the last visit to the Center.

If you **do not give us all the federal required information you cannot apply for the DFP**. If you are **unwilling to provide any of this information, please STOP HERE** and inform a member of the staff. You can still receive services, but it will not be at a discounted price.

Providing false information now, or later we find out is false, is fraud. Which means all discounts will revoked and you will immediately pay for services received without any discount.

Based on information provided, you will fall into a DFP Group. The U.S. Health Resources & Services Administration (HRSA) decides the Federal Poverty Level (FPL) range for each Group. The following discounts are available for initial services:

Group	**1**	**2**	**3**	**4**	
Federal Poverty Level	**< 101%**	**101-133%**	**134-150%**	**151-200%**	**>200%**
Medical Pediatric or GYN Visit					
Nominal Fee	$45	$50	$55	$60	No Discount
*Any additional services needed as part of your office visit are provided on a Discount Fee Schedule					
Dental Visit					
Nominal Fee without x-ray	$25	$32	$42	$48	No Discount
Nominal Fee with x-ray	$70	$100	$125	$145	No Discount
*Dental nominal fee covers the comprehensive oral examination for the initial and annual dental visit only. The type of dental cleaning and any additional services needed as part of the visit and/or subsequent visit are provided on a Discount Fee Schedule					
Prenatal Care					
Nominal Fee	$1,040	$1,160	$1,420	$1,680	No Discount
*Prenatal care nominal fee covers prenatal office visits during pregnancy and standard laboratory tests only. Any additional services needed as part of prenatal care during pregnancy are provided on a Discount Fee Schedule.					
Behavioral Health Visit					
Nominal Fee	$20	$27	$33	$39	No Discount
Laboratory					
Nominal Fee (first lab)	$30	$35	$40	$45	No Discount
(second lab)	$10	$13	$15	$18	No Discount
(third lab)	$20	$27	$30	$42	No Discount
(each additional lab)	$20	$25	$30	$35	No Discount
Radiology					
Nominal Fee (OB-GYN)	$60	$86	$105	$124	No Discount

Effective Date: **Immediate**
Approved Date: **01/30/2020**
Last Revision Date: **01/28/2020**

What is considered Income? Income includes **earnings***, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, disability benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates and trusts, educational assistance, alimony, child support, assistance from outside the household, and all other miscellaneous sources for everyone in the family/household.

Earnings* includes any amount received (direct deposit, check or cash) for worked performed (wages, salary, armed forces pay, commissions, tips, piece-rate payments, casual labor, day labor, domestic service (e.g., gardening, landscaping, housekeeping, daycare, babysitting, etc.) and cash bonuses earned and **self-employed gross income.

What determines Family/Household Size? Family/Household size can be one person, a group of people and/or one or more families living (or staying temporarily) at the same address and share common housekeeping responsibilities. **Common housekeeping responsibilities** means sharing at least one meal a day or share a common living area (e.g., living room, dining room, kitchen, etc.). Individuals in the family/household do not have to be related by blood or marriage. Individuals in the family/household includes distant relatives, friends, foster children, renters, roommates, resident domestic servants and/or **guests/visitors staying longer than 30 calendar days** (i.e., long-stay guest/visitors).

INFORMATION YOU MUST PROVIDE to determine if you qualify for discounted fees:

If A Person…	Payment Method?	Tax Return Needed	Forms Needed
Employee of a Company/ Organization	Check	Form 1040	Pay Stubs Covering Last Two Months
	Cash	Form 1040	Income Verification Form
	Just Started Work	Form 1040	Income Verification Form
Self Employed	Check / Cash Tax Return Filed	Form 1040 plus Sch C	
	Check/Cash No Tax Return Filed		Income Verification Form Bank Statements Covering Last Two Months
Currently Unemployed		Form 1040	Statement of Support Bank Statements Covering Last Two Months
Non-Employee		Form 1040	Statement of Support & IRS Form 4506T
Benefits as Income		Form 1040	
Benefits as Supplement		Form 1040	Statement of Support
Other Income		Form 1040	Statements Covering Last Two Months
Tax Return Not Filed			IRS Form 4506T
Tax Return Not Available			IRS Form 4506T

Based on information provided about family/household income and size, the patient will fall into a DFP group between 1 and 4.

Family / Household Size	Income Group 1 <101% FPL	Income Group 2 101 – 133% FPL	Income Group 3 134 – 150% FPL	Income Group 4 151 – 200 % FPL
1	$ 0 - $12,760	$ 12,761 - $16,971	$ 16,972 - $19,140	$ 19,141 - $25,520
2	$ 0 - $17,240	$ 17,241 - $22,929	$ 22,930 - $25,860	$ 25,861 - $34,480
3	$ 0 - $21,720	$ 21,721 - $28,888	$ 28,889 - $32,580	$ 32,581 - $43,440
4	$ 0 - $26,200	$ 26,201 - $34,846	$ 34,847 - $39,300	$ 39,301 - $52,400
5	$ 0 - $30,680	$ 30,681 - $40,804	$ 40,805 - $46,020	$ 46,021 - $61,360
6	$ 0 - $35,160	$ 35,161 - $46,763	$ 46,764 - $52,740	$ 52,741 - $70,320
7	$ 0 - $39,640	$ 39,641 - $52,721	$ 52,722 - $59,460	$ 59,461 - $79,280
8	$ 0 - $44,120	$ 44,121 - $58,680	$ 58,681 - $66,180	$ 66,181 - $88,240
Each additional family member, add	$4,480	$,5,958	$6,720	$8,960

Based on the revised Federal Poverty guidelines (Federal Register, Vol. 79, No. 14, January 17, 2020

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Income Verification Form – Any family/household **paid in cash** and that **cash paid is not included on the family/household tax return**, you must provide a completed and signed Income Verification form from **each employer and each non-employer** (i.e., individuals, businesses and/or organization) for services including casual labor, day labor and/or domestic service (e.g. gardening, landscaping, housekeeping, daycare, babysitting, etc.).

Means of Support – If some or all of the family/household support comes from sources other than income (e.g., checking account(s), savings account(s), investment account(s), etc.) and/or the support cannot be easily determined, the family/household must provide statements for all accounts (e.g., checking account(s), savings account(s), investment account(s), etc.) covering the two most recent months.

Statement of Support Form – If family/household gets support (cash and/or non-cash) from one or more sources (individuals, businesses and/or organization), a completed and signed Statement of Support form from **each source** providing cash and/or non-cash support. **The Statement of Support expires 30 days**. A new Statement of Support must be completed and signed before your next appointment to continue discounts in the DFP.

A maximum of three Statements of Support from the **same individual, business and/or organization** that gives the family/household support (cash and/or non-cash) is accepted. More than three is be reviewed on a case-by-case basis to determine family/household can continue discounts in the DFP.

Declaration of Shared but Separate Households Form – If family/household shares the same address with one or more other family/households for financial reasons but is otherwise separate, **each family/household must complete and sign** a Shared but Separate Household form. You can self-declare shared but separate household.

For example, Jane Doe, an uninsured patient, shares a house with her sister. The costs of maintaining occupying the house (i.e., rent or mortgage payment, insurance, property taxes, maintenance, utilities, etc.) are shared but all other living expenses are separate. Jane Doe can declare a shared but separate household when applying for DFP.

Patients with third party coverage – patients with third party insurance that does not cover or only partially covers fees for certain services may be eligible for the DFP. Depending on the Center and the third-party insurance contract agreements, the charge for each additional service will vary but that charge will never be more than maximum fee of the patient's DFP group. The insurance plan's co-pay may be lower than the DFP, in which case we will charge the lower amount.

For example, John Doe, an insured patient, receives a service that has an established fee schedule cost of $80. Based on John Doe's insurance plan, the co-pay would instead be $60 for that service. John Doe applied for the DFP. Based on family/household income and size information provided, John Doe is at 150 percent of the FPL and falls into the DFP Group 3. Under the DFP, John's established fee of $80 is discounted to a fee of $40 for this service. Rather than the $60 co-pay, John Doe pays no more than his DFP Group discount fee of $40 out-of-pocket, as long as this is not prohibited by the insurance contract terms.

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Discount Fee Program Application (page 1 of 2)

To determine if you qualify for the DFP, **it is necessary to ask personal questions about the patient and their family/household to meet federal regulations.** The answers provided by the patient and their family/household will be kept on file and in strict confidence. **Only family/household income and size are used to determine if you qualify for discounted fees.** Age, sex, race, creed, sexual orientation, disability, national origin, or legal presence/status are not considered. Government issued photo identification (identification card, driver's license, passport) is required to prove who you are. If you **do not give us all the federal required information you cannot apply for the DFP**. **Providing false information now, or later we find out is false, is fraud. Which means all discounts will revoked and you will immediately pay for services received without any discount.**

PATIENT INFORMATION

First Name	Middle Name	Last Name	Other Names

Home Address	City/State	Zip Code

Date of Birth	Social Security Number	Marital Status
/ /	--- ---	□ Single □ Married □ Divorced □ Separated □ Widowed

Primary Phone Number	Alternative Phone Number	Emergency Phone Number	Emergency Contact Name
( ) -	( ) -	( ) -	

FAMILY / HOUSEHOLD INFORMATION

Name	Date of Birth	Relationship	Enroll as a Patient? (yes or no)
	/ /		
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I have read and understand the Discount Fee Program and agree to comply with it. By signing this application page 1 of 2, I authorize the Center to confirm my family/household income and size. I verify that all information provided to determine if Family/Household qualify for the Discount Fee Program is true and correct. I understand providing false information now, or later found to be false, is fraud. Which means all discounts will revoked and I will immediately pay for services received without any discount.

_____

Completed By (Printed Patient/Responsible Person Name)

_____

Signature Date

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Approved Date: 01/30/2020
Last Revision Date: 01/28/2020

Discount Fee Program Application (page 2 of 2)

To determine if you qualify for the DFP, **it is necessary to ask personal questions about the patient and their family/household to meet federal regulations.** The answers provided by the patient and their family/household will be kept on file and in strict confidence. **Only family/household income and size are used to determine if you qualify for discounted fees.** Age, sex, race, creed, sexual orientation, disability, national origin, or legal presence/status are not considered. Government issued photo identification (identification card, driver's license, passport) is required to prove who you are. If you **do not give us all the federal required information you cannot apply for the DFP**. **Providing false information now, or later we find out is false, is fraud. Which means all discounts will revoked and you will immediately pay for services received without any discount.**

Based on information provided, my family/household size is _____ and income is $_____. These two numbers will determine which group you quality for. HRSA decides the Federal Poverty Level (FPL) range for each Group:

Family / Household Size	Income Group 1 <101% FPL	Income Group 2 101 – 133% FPL	Income Group 3 134 – 150% FPL	Income Group 4 151 – 200 % FPL
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I have read and understand the Discount Fee Program and agree to comply with it. By signing this application page 2 of 2, I understand I have fall into Group _____ based on information provided about my family/household income and size.

I authorize the Center to confirm my family/household income and size. I verify that all information provided to determine if Family/Household qualify for the Discount Fee Program is true and correct. I understand providing false information now, or later we find out is false, is fraud. Which means all discounts will revoked and I will immediately pay for services received without any discount.

_____

Completed By (Printed Patient/Responsible Person Name)

_____

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