Maple Street Clinic
109 E. Maple
Gillespie, IL 62033
217-839-1526 – Medical/Behavioral
217-839-4110 – Dental

Morgan Street Clinic
1115 Morgan Street
Carlinville, IL 62626
217-854-3692 – Medical/Behavioral
217-854-3692 – Dental

SLIDING SCALE FEE ELIGIBILITY CRITERIA

Macoupin County Public Health Clinic is a federally qualified health center that provides primary and preventative health care services to individuals who have limited access to health care due to the lack of financial resources or health insurance. To ensure that income or lack of insurance is not a barrier to health care, low-income patients who are not covered by public or private insurance are charged on a sliding fee scale. The Sliding Fee Scale Schedules are posted in the Health Center's waiting room area.

1. The Federal Poverty Income level guidelines are used to determine the discount the patient will receive **based on their income and family size.**
2. In order to be considered for evaluation for the Clinic's sliding fee scale, patients MUST provide the following information regarding the household income with them when they come to their initial appointment. **Patients will be charged full fee until proof of income has been provided.** If patient does not have physical proof of income at their first visit, verbal proof of income will be accepted. Physical proof of income must be provided prior to 60 days or next visit, whichever comes first.
3. The patient's income will be verified to meet eligibility requirements every twelve months, upon a change in patient circumstance as declared by patient or upon a change in Federal Poverty Guidelines. *NOTE* At any time the patient's financial situation changes, such as loss of income, etc., the patient may bring in new proof of income to be considered for the discounted sliding fee rates.
4. If patients state they have no income or ability to pay they will be requested to complete a Zero Income Affidavit, and zero charge will be requested for that visit; no income or ability to pay means the patient has no Unemployment, no W-2, no Tax Return, no Child Support or paycheck stubs. Zero Income affidavits will be reviewed every six months.
5. If patient has third party insurance coverage, they will be charged the lesser of the sliding scale fee discount or their patient responsibility left after insurance processing.

ACCEPTABLE FORMS OF PROOF OF INCOME

1. Two pay stubs within the last six weeks
2. Last year's tax return
   a. Gross income (Prior to deductions for income taxes, social security taxes, insurance premiums, etc.)
3. Other income records
   a. Employment Verification Statement
   b. Verification of Unemployment
   c. Self-Employment Records
   d. Zero Income Affidavit

Income is figured on base pay

Definition of Family: One or more adults and children related by blood or law and residing in the same household. Where adults other than the spouse reside together each should be considered a separate family.

Definition of Income: Income is defined as earnings over a given period of time used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource while income is comprised of earnings.

1. The Clinic uses the Federal Poverty Income level guidelines to determine the discount the patient will receive based on their income and family size.
2. If a patient wishes to be evaluated for the Clinic's sliding fee scale, they MUST bring information regarding their household income with them when they come to their initial appointment. Patient will be charged full fee until proof of income is provided.
3. To continue to qualify for sliding fees, the patient will need to provide income information once a year.

Interpretation Services will be provided upon request.

You may email your paperwork and proof of income

to MCPHD's Billing Department at:

slidingscalefee@mcphd.net

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PROOF OF INCOME

Patient Name: ____ Date of Birth: ____________________

Head of Household Name: ______________________________ Date of Birth: ____________________

Number of people in household__________________________

The names of people in the household and their relationship to patient.

Names	Relationship
________________________________	_____________________________
________________________________	_____________________________
________________________________	_____________________________
________________________________	_____________________________
________________________________	_____________________________
________________________________	_____________________________

Enter gross income amount per pay in the appropriate field below to determine yearly income:

Total Yearly Income Amount: ____

I understand that to perjure myself in order obtain assistance is a fraudulent offense for which I can be prosecuted:

Signature: ____ Date:________________

Witnessed by: ____ Date:________________

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PROMPT PAY POLICY

The Macoupin County Public Health Clinic offers a Prompt Pay Policy for those patients who do not qualify for the Sliding Fee Discount and not covered by a Third-Party Payer. The "Prompt Pay Policy" will follow the below guidelines:

Patients will be required to pay a $50 same day of service payment and will receive a same day of service discounted adjustment.

I understand that to perjure myself in order obtain assistance is a fraudulent offense for which I can be prosecuted:

Signature: ____ Date:________________

Witnessed by: ____ Date:________________

Although a patient's inability to pay for services will not prohibit services being provided, a patient who refuses to pay even though able to pay, will be subject to collection activities.

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PROOF OF INCOME WORKSHEET

(for employee use ONLY)

Patient name ________________________________

Number of people in family_____________________

Enter gross amount ___________________________

If they get paid monthly take gross amount times 12.

Gross amount_____________________

Gross Amount times 12 ______________

This amount is your yearly income

$____________________________

If they get paid biweekly take gross amount times 26.

Gross amount ________________

Gross Amount times 26 _____________

This amount is your yearly income

$___________________________

If they get paid weekly take gross amount times 52.

Gross amount ________________

Gross Amount times 52 _____________

This amount is your yearly income

$_____________________________

If they get paid bimonthly take gross amount times 24.

Gross amount ________________

Gross Amount times 24 _____________

This amount is your yearly income

$_____________________________

Completed By_______________________________________

Date____________________________

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