ECP Hospital & Clinics
INFORMATION ABOUT SLIDING FEE SCALE

What is Sliding Fee Scale?

The Sliding Fee Scale are fees for service that ECPH and Clinics use to offer adjustments on medical services provided, based on a patient's household size and income.

How do I apply?

Ask a receptionist at the front desk for an application. If you have not applied for LA Medicaid, you must do so before turning in a Sliding Fee Scale application. A denial of coverage letter from LA Medicaid is part of the required documentation for the application. Sliding Fee Scale has to be applied for every year. It is your responsibility to renew.

What if I don't apply for this service?

You will be responsible for the full amount of services provided to you at our facilities.

What if I don't bring proof of income?

You have 10 days to provide the information required to process your application. If you do not comply, you will be responsible for the full amount of services provided to you at our facilities

What services does the Sliding Fee Scale Cover?

The Sliding Fee Scale covers all services provided at East Carroll Parish Hospital and clinics.

What services are NOT covered by the Sliding Fee Scale?

The Sliding Fee Scale does **not cover** the fees for the reading of radiology tests and pathology. You **will receive a bill** from the radiologist/pathologist for the reading of those tests. Fees for professional services provided by referral physicians that are not primary care physicians at our facilities are also **not covered**.

What if my fees are still too expensive?

One of our staff representatives will direct you on the steps to take to see if you qualify for reduced healthcare with the Insurance Marketplace.

2022 HHS Poverty Guidelines

Number of Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$13,590	$16,990	$15,630
2	$18,310	$22,890	$21,060
3	$23,030	$28,790	$26,490
4	$27,750	$34,690	$31,920
5	$32,470	$40,590	$37,350
6	$37,190	$46,490	$42,780
7	$41,910	$52,390	$48,210
8	$46,630	$58,290	$53,640
For each additional person, add	$4,720	$5,900	$5,430

There are two slightly different versions of the federal poverty measure: poverty thresholds and poverty guidelines.

The **poverty thresholds** are the original version of the federal poverty measure. They are updated each year by the **Census Bureau**. The thresholds are used mainly for **statistical** purposes — for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines). Poverty thresholds since 1973 (and for selected earlier years) and weighted average poverty thresholds since 1959 are available on the Census Bureau's Web site. For an example of how the Census Bureau applies the thresholds to a family's income to determine its poverty status, see "How the Census Bureau Measures Poverty" on the Census Bureau's web site.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the Federal Register by the **Department of Health and Human Services** (HHS). The guidelines are a simplification of the poverty thresholds for use for **administrative** purposes — for instance, determining financial eligibility for certain federal programs. The poverty guidelines are sometimes loosely referred to as the "federal poverty level" (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.

Key differences between poverty thresholds and poverty guidelines are outlined in a table under Frequently Asked Questions (FAQs). See also the discussion of this topic on the Institute for Research on Poverty's web site.

The January 2022 poverty guidelines are calculated by taking the 2020 Census Bureau's poverty thresholds and adjusting them for price changes between 2020 and 2021 using the Consumer Price Index (CPI-U). The poverty thresholds used by the Census Bureau for statistical purposes are complex and are not composed of standardized increments between family sizes. Since many program officials prefer to use guidelines with uniform increments across family sizes, the poverty guidelines include rounding and standardizing adjustments.

ECP Hospital & Clinics Sliding Fee Scale Application

Patient Information		**Today's Date: / /**			
First Name:	Middle:	Last:		Other names:	
Home Address:		City:		State:	Zip:
Mailing Address:		City:		State:	Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -			
Date of Birth: / /	Social Security # - -		Legal Sex: **Male** **Female**		
Do you have insurance? **Yes No**	Marital Status: **Single** **In a relationship** **Married** **Divorced** **Separated** **Widowed**				

Dependents		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

Household Annual Income

Name	**Amount**	**Source of Income (employment, SS checks, child support, etc.)**	**Employer:**
You	$		
Spouse	$		
Children	$		
Other	$		
	$		
TOTAL	$		

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security/SSI/SSDI					
State Public Assistance					
VA Retirement/Disability					
Child Support, Alimony					
VA Retirement/Disability					
Other					
				TOTAL	**$**

NOTE: To comply with federal regulations, in order to give you a discount for medical services, it is necessary for us to ask you some personal questions. Your answers will be kept on file and in strict confidence. **It is your responsibility to verify your income every year**.

Required Documents: Recent copy of your LA Medicaid denial of coverage letter. Valid Driver's license/ID, a recent copy of your income tax return & W-2 form, last 4 paycheck stubs (if tax return is not available), & copy of your social security checks or other checks you receive monthly.

Sliding Fee Scale:

A – $15 Minimum Payment

B – 80% Discount

C – 60% Discount

D – 40% Discount

E – 25%Discount

****Please provide receptionist with insurance cards** Add additional dependents on back.**

"This is an equal opportunity provider."

PLEASE SUPPLY REQUIRED INFORMATION TO PROCESS YOUR APPLICATION WITHIN 10 DAYS

I do hereby swear that the information provided on this application is true and correct to the best of my knowledge. I understand that if my household's monthly gross income changes, I have to complete a new application and provide proof of the new income. I give East Carroll Parish Hospital and Clinics permission to verify information about my financial status. I understand that any misleading or falsified information, and/or failure to meet the required conditions may disqualify me from further consideration for the sliding fee program and future Sliding Fee Scale discounts. I authorize the release of any medical or other information necessary to process claims on my behalf to facilitate my care or the care of my minor child. If acceptance to the sliding fee program is obtained under this application, I understand that this does not mean that all medical services provided are free and I am responsible for any remaining balances. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____

Name (Print):_____

Signature:_____

****For ECPH|Clinics Central Billing Use Only****

Application approved for Sliding Fee Scale (SFS), letter will be mailed to applicant: Yes No

Patient Responsibility: _____

Effective Date: _____ **Termination Date: _____**

Date: _____

_____
Lindsay Layton LPN, Clinic & Central Billing Mgr

Additional Dependents		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

"This is an equal opportunity provider."