Sliding Fee Requirements:				
☐ No other medical insurance policy coverage	☐ Denial from RH Navigator	☐ Previous year's tax return	☐ 4 weeks/1 month income from current date for each wage earner in the household	☐ Photo ID

FINANCIAL ELIGIBILITY APPLICATION

Randolph Medical Associates
PO Box 5448
Asheboro, NC 27204
336.625.6072

Account #_____ Application Date:_____

1. Name Last _____ First _____ MI _____

2. Patient SS#: __ __ __-__ __-__ __ __ __ **3. Date of Birth**___/___/____ **4. Sex** O Male O Female

5. Race: O Caucasian O African American O American Indian O Hispanic O Asian Pacific O Other **6. County of Residence** _____

Address_____

City_____ **State**_____ **Zip**_____

Telephone# Home_____ Work_____ Cell_____

7. Number in family: (Adults)_____(Children)_____(Total in Family)_____

8. Income Formulas-Continuously employed wage earners must show income from four (4) weeks income.

9. Patient and Family Member in Household Income Information

Patient & Family Member in Household (Name)	Relationship to Patient	Sources of Income Reason for None for 12 Month Period	Gross Income	Date of Birth	Patient Account #
Applicant Name:					
Spouse/Dependent:					
Dependent					
Dependent					
Dependent					
Dependent					

Total Gross Family Income$

10. Eligibility for other Programs:

Medicare Part A O Yes O No O Pending Medicare Part B O Yes O No O Pending
Medicaid O Yes O No O Pending Medicaid# _____Eligibility Date_____
Any Insurance Exchange Carrier O Yes O No O Pending

11. I hereby certify that I have read or the interviewer has read to me the terms and conditions contained on this form and that I agree to comply with them. I also certify that I have been provided opportunity to ask the interviewer questions about these terms and conditions and that I understand the answers I was given.

Applicants Signature_____ **Date**_____

12. I certify that I explained the terms and conditions contained on this form to the applicant and have witness his signature.

Interviewer's Signature_____ **Date**_____

Approved by:_____ **% Discount** _____ **Date**_____

RANDOLPH MEDICAL ASSOCIATES AND RANDOLPH SPECIALTY GROUP POLICY

	Title:	**Sliding Fee Policy**
	Policy:	*INS-007*
	Scope:	**Practice-Wide**
	Effective Date:	*10/17/2014*
	Last Review Date:	**1/12/2015**
Prepared by:	**Approved By:**	Robert Clauser, President

I. POLICY

RMA will provide a means for healthcare services for those patients with financial need who have no other assistance to satisfy their account balance either personally or through insurance, Medicaid, etc.

II. PURPOSE

To establish financial need based on Federal poverty guidelines (RMA/RSG Shared Folder) and appropriate documentation and determine reasonable payment arrangements within the proven eligibility level.

III. IMPLEMENTATION

A. An established self-pay patient (having no insurance coverage), living in only the communities that we currently serve, expresses a need for financial assistance or an inability to pay amount due for services.

B. Receptionist presents patient with a copy of the RMA Sliding Fee Information Sheet and discusses this with the patient.

C. If patient expresses an interest, receptionist arranges a time for patient to complete an application with a Patient Account Representative.

D. Receptionist will charge RMA regular fees at this time and collect according to RMA Policy, until which time the patient goes through the sliding fee process pending approval.

E. Patient Account Representative will assist patient in completion of the Financial Application Form and instruct them to bring in copies of a pay stub – 4 weeks /1 month current date, previous year's tax return, and a denial from Randolph Hospital-Navigator.

F. Upon its return, the Patient Account Representative will review the form and supporting documents to determine eligibility based on need. The Patient Account Director will then need to approve.

G. Need will be determined by using the HHS Poverty Guidelines. If a patient is determined to meet the guidelines for 100% discount, they will be responsible for a $5 copay at each visit. If the patient is determined to the meet the guidelines for an 80% discount, they will be responsible for a $20 copay. All other patients that qualify for a discount will receive the corresponding percentage discount.

H. Once patient is determined eligible or ineligible, Patient Account Rep will inform the patient.

I. Patient Account Rep will enter the sliding fee adjustment as "Sliding Fee Adjustment" on the patient's account based on the patient's eligibility per the Poverty Guidelines.

J. Patient Account Representative will review all Sliding Fee Accounts before each billing cycle is run for additional adjustments to subsequent charges.

K. Sliding Fee Eligibility Determination is effective for the current calendar year and patients must reapply annually.

IV. RESPONSIBILITY FOR INTERPRETATION

The Patient Account Director will be responsible for interpretation of this policy.

Original Date

_____

Special Approval	**Signature**	**Date**
_____	_____	_____