

Sliding Fee Discount Information

An Exceptional Patient Experience

East Hill Medical Center (EHMC) believes that everyone deserves quality healthcare regardless of one's ability to pay. EHMC offers a sliding fee discount program that is designed to provide discounted care to those who have limited or no means to pay for their medical/dental services. In addition to quality healthcare, patients are entitled to financial counseling by someone who can understand and offer possible solutions for those who cannot pay in full.

Eligibility: Discounts will be based on annual income and family size only. EHMC uses the Census Bureau definitions of each.

- **Family** is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.
- **Income** includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. *Noncash benefits (such as food stamps and housing subsidies) do not count.*

Income verification: Applicants must provide one of the following:

- Prior year W-2
- Two most recent pay stubs
- letter from employer
- Form 4506-T (if W-2 not filed)

Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program.

Patients who are not able to provide written verification must provide a signed statement of income and why they are unable to provide independent verification.

Each applicant will have two weeks from the date of application to provide income verification. If you do not provide the information requested above during those two weeks, your application will be denied and all services will be billed at full charge. By either declining to submit the Sliding Fee Discount Application or not providing the required documents, you agree that you have both the **ability** and the **willingness** to pay for any medical bills you may get from our offices, and that you are responsible to pay them within 30 days of receiving the bill.

Information may be delivered or sent to:

East Hill Medical Center
144 Genesee Street
Suite 500
Auburn, NY 13021

Or, you may e-mail your application and income verification to ehbilling@easthillmedical.com

The Sliding Fee Discount Program determination will be provided to you in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If you have any questions, please call EHMC's Billing Office at 315.253.8477 prompt #6.

Sliding Fee Discount Application

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It is the policy of East Hill Medical Center, Inc. to provide essential services regardless of the patient's ability to pay. Discounts are offered based on Family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to services received at this clinic, but not those services or equipment that are purchased from outside facilities, including reference laboratory testing, medications, and other such services. This form must be completed every 12 months or if your financial situation changes.

Household Information				
Name of Head of Household:			Place of Employment:	
Address Street:		Apartment #:	Phone Number:	
City:	State:	Zip Code:		
Please list spouse and dependents under age 18:				
Name	Date of Birth	Name	Date of Birth	
Self		Dependent		
Spouse		Dependent		
Dependent		Dependent		
Dependent		Dependent		
Annual Household Income				
Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents.				
Unemployment compensation, worker' compensation, Social Security, Supplemental Security income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
TOTAL				
<i>Check only one:</i> <input type="checkbox"/> I certify that the family size and income information shown above is correct. <i>NOTE: Copies of tax returns, pay stubs, or other information verifying income will be required before a discount is approved.</i> <input type="checkbox"/> I decline to complete the application to determine my eligibility for the East Hill Medical Center, Inc. schedule of discounts. I understand that signing this declination means that I am accepting responsibility for all services at full charge and that payment will be my responsibility.				
Name (Print)			Date:	
Signature				

For office use only: ☐ Eligible for ____% discount ☐ Ineligible Signature: _____ Date: _____