Patient Name_____ **Date of Birth**_____

POLICY

Kintegra Health is dedicated to providing quality health care including health education and preventative care services to all members of the community regardless of financial barriers (ability to pay) through regular publication of a sliding fee scale.

Underinsured/Uninsured patients of Kintegra Health, Inc. with a household income at or below 200% of the Federal poverty level (FPL) and that provide required documentation will be eligible for medical, dental, and prescription discounts. Kintegra Health will annually revise and re-issue its sliding scale to reflect changes in the Federal Poverty guidelines.

Kintegra Health

SLIDING SCALE FEE APPLICATION

Patient Name (First, Middle, Last): _____ Date of Birth: _____

Mailing Address: _____ Phone: _____

City, State, Zip: _____ SS#: _____

Total in Family Unit: _____ Number of Adults _____ Number of Children _____

Do you have Health Insurance or Medicaid? YES _____ NO _____ If yes, What type? _____

SOURCES OF INCOME FOR APPLICANT AND PERSONS IN THE FAMILY (Dependents)

*****Applicant must provide documentation with the application. A list of appropriate documents is listed below. Provide the documents that are applicable to you and your family.**

- **Applicant's Salary** - Provide at least one of the following as applicable to you:
  - **30 days of most recent pay statements** i.e. weekly (4), bi-wkly or semi-mthly (2) monthly (1)
  - Letter on letterhead from employer that states current hourly rate and normal number of hours in work week
  - If self-employed, provide your most recent tax returns including 1099 Schedule C
- **Other Family Member's Salary**: Provide at least one of the items required for the applicant's salary.
- If unemployed (either applicant or other family members), please provide:
  - Wage history (from Employment Security Commission) AND
  - Unemployment Wage Summary (from E.S.C.)
- Current statement for disability, social security, and/or pension showing monthly earnings
- Alimony and/or child support – Indicate amount paid or provide statement of monthly alimony and/or child support income.
- Worker's compensation benefits
- VA/pension income
- Public Assistance
- Food Stamp Verification
- **No source of income** - Provide us with a letter that supports your current financial status. This letter may ONLY come from a minister/priest/rabbi, director of a homeless shelter, landlord, or social/case worker. Complete and provide the 'Verification of income received from relatives/friends' form (Notarized).

Patient Name_____ **Date of Birth**_____

Kintegra Health

Total in Family Unit _____ Number of Adults _____ Number of Children _____ Under18 _____

PLEASE LIST HOUSEHOLD INCOME BELOW

Household is defined by Kintegra as the taxpayer plus his/her dependents

If you file jointly then you will need to supply income for both taxpayers. A copy of the most recent tax return is recommended

Name	DOB	Relationship	Gross Income $	Frequency of Payment	Source
		Applicant		( ) Wkly ( ) Bi-wkly ( ) Mthly ( ) Semi-mthly ( ) Annually	
				( ) Wkly ( ) Bi-wkly ( ) Mthly ( ) Semi-mthly ( ) Annually	
				( ) Wkly ( ) Bi-wkly ( ) Mthly ( ) Semi-mthly ( ) Annually	
				( ) Wkly ( ) Bi-wkly ( ) Mthly ( ) Semi-mthly ( ) Annually	

Total Household Gross Income: $_____ / yr.

( ) Pay Stmts. ( ) Direct Deposit/Bank Statement ( ) Social Security/Disability Letter ( ) Food Stamp Letter
( ) Relatives/Friends Contribution Form ( ) Zero Income Affidavit ( ) Tax Return ( ) W-2 ( ) Child Support Verif.

Weekly	Bi-wkly	Semi-mthly	Monthly
stmt. gross 1	stmt. gross.1	stmt. gross.1	stmt. gross 1
stmt. gross 2	stmt. gross 2	stmt. gross.1	
stmt. gross 3			
stmt. gross 4			
Total	Total		Total
X 13	X 13	X 12	X12
Total	Total	Total	Total

Patient Name_____ **Date of Birth**_____

- All of the information provided on this application is true and correct and the applicant has not omitted any material matters in providing the information.
- At any time there is a change in the total family income or health care coverage, Kintegra Health will be notified and such change will be supported by the submission of appropriate documentation.
- Approval of this application is limited to a maximum of (1) Year from the date of approval.
- The applicant is at least 18 years old, has been declared by a court to be emancipated, or is emancipated by marriage or other legal definition.
- If the applicant participates in pharmaceutical assistance programs offered by Kintegra Health' pharmacy department, permission is given for the pharmaceutical companies or its designees to review records for audit purposes.

I agree that failure to provide proof of income will remove me and my family from the Kintegra Health, Inc. sliding fee scale discount program. I understand that my fees are based on the financial information which I have provided and agree that the information provided is true and includes all household income. I agree to notify Kintegra Health, Inc. of any and all changes to my insurance status and/or household income.

X _____ _____

Signature of Applicant or Parent/Guardian **Date Signed**

_____ _____

Kintegra Health Witness Signature **Date Signed**

SLIDING SCALE FEE APPLICATION CHECKLIST

***** TO BE COMPLETED BY KINTEGRA HEALTH STAFF ONLY *****

Patient Name _____ **Date of Birth** _____ **MR#** _____

Documents Provided by Applicant

☐ **Completed Sliding Scale Fee Application**

☐ **Proof of Residency Verification**

- ☐ Driver's License
- ☐ State Identification
- ☐ Utility Bill
- ☐ Letter from Residential Treatment Facility/ Residential Transition Program/ Community Reentry Program
- ☐ Other_____

☐ **Proof of Income – Provide AT LEAST One (1) for EACH adult in the household:**

- ☐ **30 Days** of most recent pay statements i.e. weekly (4), bi-wkly or semi-mthly (2) monthly (1)
- ☐ Letter on letterhead from employer stating your current rate of pay & hrs in 1 week
- ☐ W-2 Form
- ☐ Most recent tax returns including (1099 Schedule C if Self-employed)
- ☐ Social Security/ Disability Income Statement Letter
- ☐ Unemployment Wage Summary from (Employment Security Commission)
- ☐ Child Support/Alimony Verification letter
- ☐ Food Stamp Verification letter
- ☐ Bank Statement
- ☐ VA/Pension Income
- ☐ Worker's Compensation benefits
- ☐ A letter that supports your current financial status. **(This letter may ONLY come from a minister/priest/rabbi, director of a homeless shelter, landlord, or social/case worker.)**
- ☐ OTHER (List) - ( ) Relatives/Friends Contribution Form ( ) Zero Income Affidavit

_____

_____

Verifications Obtained – ***MANDATORY (for office use)

☐ **Printed screen showing a COVERAGE Verification**. Obtained at https://webclaims.ncmedicaid.com/ncecs/. Or https://online.instamed.com

Reviewed and verifications completed by: _____ **Date:** _____

Eligibility Dates: START _____ **STOP** _____ **Copay Med:** _____ **%**_____

( ) No PP Benefits

Medication Assistance Program Guidelines

Patient Name_____ **Date of Birth** _____

Obtaining medications through the Medication Assistance Program (MAP) is a gift and cannot be guaranteed to be available or to arrive on time. It is your responsibility to obtain your own medications if this happens. Drug companies as well as KINTEGRA HEALTH reserve the right to remove medication from their program at any time.

If you filed taxes within the latest taxable year we require your 1040 forms. If you did not file and were not claimed as a dependent on someone else's tax forms we will need you to sign a 4506 T form stating this. If neither of these apply to you, we need copies of the most recent paychecks verifying household income for the last month. If there is no household income we will need you to file for Medicaid and bring us a denial letter stating you cannot be covered on Medicaid and a letter of who is supporting you.

Once you have been approved for MAP and to remain active you must notify both the MAP and Pharmacy offices of any changes made to medication, household income, address, phone numbers, or if you obtain insurance or Medicaid. When initially enrolled it could take up to 8 weeks or longer for meds to arrive (although the drug company could mail you notification that they have already shipped we still have to process the medication in our system). KINTEGRA HEALTH must receive all meds shipped directly to us to ensure you of an accurate reorder date. However, you must notify us if they are shipped to your home by mistake. Also it is very important for you to call us if you receive any paperwork in the mail from the drug company.

When your medications are ready to be picked up you will receive an automated phone call from the pharmacy. The medications that you receive through MAP are free but there will be a $6.00 processing fee to be paid to the pharmacy for each 90 day supply at the time of pickup. You will have 30 days to pick up your medicine or it will be returned to stock and you can be discharged from the program for being non-compliant.

<u>To be eligible to receive medication through MAP we require you signature giving us permission for us to: Sign your name on applications and letters from prescription assistance programs only; attest that you do not have insurance, Veterans Affairs or Medicaid and that you will notify us of any changes in your circumstances.</u>

If you have any questions or concerns in relation to the Medication Assistance Program please contact the Community Resource Advocate at your Clinic.

X_____

Patient Signature Date

_____

Kintegra Health Witness Signature Date