

### SLIDING FEE SCALE PROGRAM

ConnexCare offers a sliding fee scale. This means we can reduce your charges for services based upon your household's income. If you have insurance, we will adjust only the portion that you must pay. Once approved for sliding fee, your coverage is valid for one year. You must re-certify every year to maintain your coverage.

Our sliding fee scale program will also pay a portion of your medical lab and pharmacy bills if you have no insurance coverage. This laboratory benefit is only available for lab work done through Oswego Hospital Laboratories. A provider of ConnexCare must order prescriptions and lab work.

If you are eligible for patient assisted medicine, we do require you to apply. All Medicare applicants who are 65 or older will be required to enroll in EPIC, New York State's prescription plan for seniors. The sliding fee program will reimburse you for EPIC's annual fee and all prescription co-pays at the level of program discount. For example, if you qualify for 75% sliding fee, we will reimburse you 75% of your annual fee and co-pays. A form is available from our Outreach and Access Representatives to submit receipts for reimbursement. Receipts may be submitted at any time; however we will only send checks quarterly. Reimbursement checks will be issued at the end of March, June, September and December for all receipts submitted to date.

Please check the income chart below. If your gross yearly household income appears on the line that shows your household size, you may be eligible for reduced charges. Complete the application form on the reverse side and bring it to the front desk at one of our health centers so that we can set up an appointment for you with one of our Outreach and Access Representatives. You may also mail the form with necessary income verification to the address above and we will contact you to set up an appointment. If you have any questions you can call the **Pulaski location at 298-6564 and ask to speak with our Outreach and Access Representative.**

**All sliding fee patients are asked to pay a nominal visit fee of \$15.00.**

Household Members	100% discount		75% discount		50% discount		25% discount	
1	0	15,060	15,061	20,081	20,082	25,102	25,103	30,120
2	0	20,440	20,441	27,254	27,255	34,069	34,070	40,880
3	0	25,820	25,821	34,428	34,429	43,035	43,036	51,640
4	0	31,200	31,201	41,601	41,602	52,002	52,003	62,400
5	0	36,580	36,581	48,774	48,775	60,969	60,970	73,160
6	0	41,960	41,961	55,948	55,949	69,935	69,936	83,920
7	0	47,340	47,341	63,121	63,122	78,902	78,903	94,680
8	0	52,720	52,721	70,294	70,295	87,869	87,870	105,440
9	0	58,100	58,101	77,468	77,469	96,835	96,836	116,200
10	0	63,480	63,481	84,641	84,642	105,802	105,803	126,960
11	0	68,860	68,861	91,814	91,815	114,769	114,770	137,720
12	0	74,240	74,241	98,988	98,989	123,735	123,736	148,480

**APPLICATION FOR SLIDING FEE SCALE ADJUSTMENT**  
**\*\*\*PLEASE BRING VERIFICATION OF INCOME\*\*\***

**Please see attached checklist for acceptable forms of verification.**

Please complete items 1-5 and return.



61 Delano Street, Pulaski, New York 13142-1400  
 Phone: (315) 298-6569 Fax: (315) 298-7488 TDD: 711  
 www.connextcare.org

1. NAME: \_\_\_\_\_  
                     First                                    Middle                                    Last  
 ADDRESS: \_\_\_\_\_  
                     Number and Street                    City                    State                    Zip  
 TELEPHONE: \_\_\_\_\_

2. **CURRENT EMPLOYER:** \_\_\_\_\_  
**ADDRESS & PHONE #:** \_\_\_\_\_

3. **INCOME:** List income for the household from:

	Current Monthly	Last 12 Month Total
Wages or self-employed.....	_____	_____
Public Assistance or Social Security.....	_____	_____
Unemployment or Workmen’s Comp.....	_____	_____
Alimony or Child Support.....	_____	_____
Pensions/Annuities.....	_____	_____
Income from rent, dividends, interest, and any other source.....	_____	_____

4. Do you have any other insurance?..... \_\_\_\_\_  
 If so, what kind?..... \_\_\_\_\_  
 Identification #..... \_\_\_\_\_

5. **HOUSEHOLD SIZE:**

<i>NAME</i>	<u>RELATIONSHIP</u>	<u>DATE OF BIRTH</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of the applicant \_\_\_\_\_ Date \_\_\_\_\_

.....  
**FOR OFFICE USE ONLY**

Qualifies for: \_\_\_\_\_% Discount \_\_\_\_\_ Ineligible  
 Date of determination: \_\_\_\_\_ Signature: \_\_\_\_\_