ConnextCare™
A Community of Care

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

SLIDING FEE SCALE PROGRAM

ConnextCare 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 ConnextCare 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 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	Medicaid Eligible	75% discount	50% discount	25% discount
1	0 - 15,650	15,651 - 20,868	20,869 - 26,085	26,086 - 31,300
2	0 - 21,150	21,151 - 28,201	28,202 - 35,252	35,253 - 42,300
3	0 - 26,650	26,651 - 35,534	35,535 - 44,419	44,420 - 53,300
4	0 - 32,150	32,151 - 42,868	42,869 - 53,585	53,586 - 64,300
5	0 - 37,650	37,651 - 50,201	50,202 - 62,752	62,753 - 75,300
6	0 - 43,150	43,151 - 57,534	57,535 - 71,919	71,920 - 86,300
7	0 - 48,650	48,651 - 64,868	64,869 - 81,085	81,086 - 97,300
8	0 - 54,150	54,151 - 72,201	72,202 - 90,252	90,253 - 108,300
9	0 - 59,650	59,651 - 79,534	79,535 - 99,419	99,420 - 119,300
10	0 - 65,150	65,151 - 86,868	86,869 - 108,585	108,586 - 130,300
11	0 - 70,650	70,651 - 94,201	94,202 - 117,752	117,753 - 141,300
12	0 - 76,150	76,151 - 101,534	101,535 - 126,919	126,920 - 152,300

APPLICATION FOR SLIDING FEE SCALE ADJUSTMENT

*****PLEASE BRING VERIFICATION OF INCOME*****

Please see attached checklist for acceptable forms of verification.

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

2. **CURRENT EMPLOYER:** ______________________________________
   ADDRESS & PHONE #: ______________________________________

   Or, Are you homeless? Yes_________ No________ If yes- What is your current status:
   ☐ Homeless shelter ☐ Transitional ☐ Doubling up ☐ On the street

3. Are you a veteran? Yes_________ No_________
4. Do you live in public Housing? Yes________ No________
5. **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..	____________	____________

6. Do you have any other insurance?............................ ______________________
   If so, what kind?.. ______________________
   Identification #…………………………………….. ______________________

7. **HOUSEHOLD SIZE**:

NAME	RELATIONSHIP	DATE OF BIRTH
____________________	________________	____________
____________________	________________	____________
____________________	________________	____________
____________________	________________	____________
____________________	________________	____________
____________________	________________	____________

Signature of the Applicant ___________________________________Date ____________

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FOR OFFICE USE ONLY
Qualifies for: _____% Discount _____ Ineligible Date of determination: ____________
Signature: ______________________________

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The following documents need to be included with the Sliding Fee application and are acceptable forms of income. Please include paper documentation for everyone in the household, related or not. We will be unable to process the application without all of the required information.

- Current Federal Income Tax filing
- The last three (3) pay stubs if weekly, two (2) if by-weekly
- Any alimony or child support
- Public Assistance or Social Security
- Unemployment or Workmen's Compensation
- Pensions or Annuities
- Income from rent, dividends, interest, or any other source

Thank you,
Outreach and Access Representative