310 E Broadway, Suite 100
Louisville, KY 40202

<u>SLIDING FEE DISCOUNT PROGRAM</u>

The Have A Heart Clinic is a 501 (c)(3) nonprofit health clinic that provides high quality cardiovascular care. All patients may apply for a sliding fee scale discount based on their family/household size and income.

Are you **UNINSURED**?

- Is your income below **200% of the federal poverty level**? You are eligible to receive **FREE CARE.**
- Is your income more than **200% of the federal poverty level**? You will only pay the Medicare allowable charge

Are you **INSURED**?

- **We will bill your Insurance.**
- If your income is **at or below 200% of the federal poverty level, you will not pay co-insurance, copays, and/or deductibles**.

The 2022 Federal Poverty Level Chart is on the next page. Please review the chart to determine your income level, as you may qualify for discounted or free services.

TO BE ELIGIBLE FOR FREE OR DISCOUNTED SERVICES, ALL PAGES OF THE FINANCIAL HARDSHIP APPLICATION MUST BE COMPLETED AND INCOME MUT BE VERIFIED.

If you have any questions about the Medicare Allowable charges, please call or office at 502-245-0002

2022 Federal Poverty Guidelines		
Household Size	200% Of Poverty Level	
# Of Persons	Annual	Monthly
1	$27,180	$2,265
2	$36,620	$3,052
3	$46,060	$3,838
4	$55,500	$4,625
5	$64,940	$5,412
6	$74,380	$6,198
7	$83,820	$6,985
8	$93,260	$7,772

Financial Discount Application

To be considered for a financial discount, you will need to complete Have A heart Clinic's Financial Hardship Application and include income for all household members.

Proof of Income

Acceptable proof of income may include:

- Copy of last month's pay subs
- Unemployment verification, social security award letter
- Copy of most recent tax return or W2
- *If you have no income, a letter that explains your means of living or a completed **Attestation of Income Form** (included in the Financial Hardship Application)*

If you do not supply adequate proof of income or qualify based on the information submitted, you will be responsible for all charges and will be expected to pay at check-in for each visit.

We are here to serve you. We rely upon your honesty. ALL FORMS MUST BE COMPLETELY FILLED OUT FOR CONSIDERATION.

Thank you,

Have A Heart Clinic

FINANCIAL HARDSHIP APPLICATION

Patient's Name ____________________ Patient's Date of Birth ____________________

Patient's Contact Information:

Street Address ____________________ Apt. # __________ City ____________________

State __________ Zip __________

Home Phone: ____________________

Cell Phone: ____________________

Home Email Address: ____________________

Patient's Family Information:

Marital Status (Check One): ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

Spouse's Place of Employment: ____________________

Spouse's Name: ____________________

Spouse's Date of Birth: ____________________

Spouse's Cell Phone: ____________________

Spouse's Work Phone: ____________________

Please list the name, age and relationship of all persons residing in your household. If a household member is over 18, please note if the individual is a student.

NAME	**Date of Birth**	**Relationship**

Patient's Health Information:

Insurance at time of service (Please Check one) ☐No Insurance ☐Medicare ☐Medicaid ☐Other:________________________________

Have you applied for federal or state medical assistance? ☐Yes ☐No

If Yes, when did you apply: ______________________________

If No, why? ______________________________

Patient's Work Information:

Place of Employment: ______________________________

Occupation: ______________________________

Work Phone: ______________________________

Years of Employment: ______________________________

Patient's Income Information:

Please list all household income (wages, retirement pensions, disability income, interest income, unemployment benefits, workers compensation benefits, AFDC payments, social security, child support, etc.) for the past 12 months.

____

____

____

ATTACH COPIES OF THE FOLLOWING DOCUMENTS THAT APPLY TO VERIFY YOUR INCOME:

- PRIOR YEAR'S FEDERAL TAX RETURN or W-2
- PAY STUBS FROM THE PAST 3 MONTHS
- UNEMPLOYMENT BENEFIT STATEMENTS
- SOCIAL SECURITY BENEFITS LETTER
- DISABILITY BENEFITS LETTER
- EMPLOYER LETTER TO VERIFY CASH INCOME

I understand that by signing this form, I certify that all information listed and provided is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by *Have a Heart* and I give permission to *Have a Heart* to share the information as necessary to consider my financial assistance request. I hereby grant permission to *Have a Heart* to investigate the information contained herein, and to obtain credit reports. I understand that *Have a Heart* may deny my application for Financial Hardship Assistance if I do not meet the Financial Hardship Assistance criteria or if the information provided by me is inaccurate, incomplete, or fraudulent.

Date: ____________ Signature: _____________________________________

Address, City, State, Zip____

Date of Birth: _______________________ SSN: ________________________

STATEMENT OF "NO FILE STATUS" FOR FEDERAL INCOME TAXES

I, ________________________ (print name), hereby certify that I have not filed federal income tax forms with the United States Internal Revenue Service in the past ______ years due to low-income status.

I also certify I was not claimed as a dependent on another person's Federal Income Tax return for the prior year.

I understand that by signing this form, I certify that all information listed and provided is true and correct to the best of my knowledge. I hereby grant permission to *Have a Heart* to investigate the information contained herein.

Date: ____________ Signature: ______________________________________

Address, City, State, Zip____

Date of Birth: _______________________ SSN: ________________________

Have A Heart Self Declaration of Income

☐ I declare that I have been working and receiving payment in cash in the amount of $______ per (circle one): day week two weeks month

____I have no check stubs or other documentation to prove my earnings.

☐ I declare that I have no employment and do not have income of any kind.

By signing below, I certify that everything I have stated on this Declaration is true and correct to the best of my knowledge.

Date: ____________ Signature: ______________________________________

Address, City, State, Zip____

Date of Birth: _______________________ SSN: ________________________