Information about Sliding Scale

What is sliding scale?

A sliding scale is the method we use to offer discounts on healthcare from Delhi Hospital, Delhi Community Health Center, and Delhi Rural Health Clinic based on a patient's household size and income.

What happens if I don't apply?

You will be asked to pay the full charges for the services provided if you choose not to apply.

How can I prove my income?

- Payroll check that shows your year-to-date income
- One moth of current pay stubs
- Current wage statements (written from employer)
- One moth of current unemployment check stubs
- Current bank statement that shows flow of money in/out of account
- Current statement from Social Security office
- Letter from the individual who supports the patient financially. The letter must state a specific dollar amount.

What if I don't bring proof of income?

You will receive a bill for the full cost of your visit/services from Delhi Hospital, community Health Center or Rural Health Clinic, wherever you received services from.

What if this information changes?

If your income or household size changes, please inform the receptionist. You will be asked to fill out a new application and show proof of the new income.

What services does Sliding Scale cover?

Sliding scale offers discounts on the clinic visits and all services provided at Delhi Hospital.

What services are NOT COVERED under Sliding Scale?

Sliding Scale does not cover the cost of pathology and the reading of the radiology test done by the radiologist. You will still receive a bill from the pathologist or radiologist if those services were done. Also, Sliding Scale does not cover professional services provided by referral physicians that are not primary care physicians at one of our facilities.

What if my fees are still too expensive?

One of our clinic staff will direct you to the appropriate Certified Applications Counselors at our facility to see if you qualify for reduced cost healthcare with Medicaid or the Insurance Marketplace.

Delhi Hospital and Clinics

Sliding Scale Discount Application

Sliding Scale is a discount program we offer to our uninsured patients. The discount you qualify for is based on your household size and income. Please fill out this application and **provide proof of monthly gross income for ALL members of the household** to the receptionist. If you have questions, see the information on the next page or ask the receptionist for help.

Last Name:_____ First Name:_____ MI____ Jr. Sr. III

Date of Birth: ____/____/_____ Social Security #: _____-_____-_____

Mailing Address: _____
Address City State Zip

Home (____)_____-_____ Cell (____)_____-_____ Work (____)_____-_____

Insurance Information

Company Name:_____

Policy or Card #:_____

Policy Holder's Last Name: _____ First Name:_____

Policy Holder's DOB: _____/_____/_____ Policy Holder's SSN# _____-_____-_____

Policy Holder's Address:_____
Address City State Zip

Household Members and Income

Are you receiving any one of the following benefits? (We must have copies of any that are marked YES. Without proof of income, you will not receive a discounted price)

	Y	N	If so, how much?
Medical Assistance			
State Public Assistance			
SSI/SSDI			
Social Security			
Veterans Retirement/Disability			
Workers Compensation			
Unemployment			
Other (Alimony, Child Support)			

Are you currently employed?

YES / NO

What is your gross annual income?

_$_____

Place of employment:

_____

Employer Phone #

(____) _____-_____

Annual Income in your household

☐ $10,000 - $20,000	☐ $36,000 - $40,000	☐ $51,000 +
☐ $21,000 - $35,000	☐ $41,000 - $50,000	

How many people live in your household? _____

List their names, birth dates, income, & SSN if available

Name	Date of Birth	SSN#	Relationship	Annual Income
	___/___/_____	____-____-____		
	___/___/_____	____-____-____		
	___/___/_____	____-____-____		
	___/___/_____	____-____-____		
	___/___/_____	____-____-____		
	___/___/_____	____-____-____		
	___/___/_____	____-____-____		
	___/___/_____	____-____-____		
Total monthly gross household income (earned and unearned): $_____				

Required Documentation Checklist. Have you included:

- A copy of your W-2 Withholding Forms
- A copy of Recent Tax Returns
- A copy of Last 4 check stubs (if tax return is not available)
- A copy of Forms Approving/Denying Unemployment Compensation or Workman's Compensation
- A copy of Last Bank Statement

TO RETAIN SLIDING FEE SCALE PRIVILEGES, PROOF OF INCOME MUST BE SUPPLIED WITHIN 10 DAYS OF THIS APPLICATION.

"This information is true and correct to the best of my knowledge. I understand that if my household's monthly gross income changes, I must fill out a new application and show proof of the new income amount. I give Delhi Hospital and Clinics permission to verify information about my financial status. Failure to meet those conditions may disqualify me from the future Sliding Scale fee discounts. I authorize the release of any medical or other information necessary to process claims on my behalf or as necessary to facilitate my care or the care or the care of my minor child. I understand that by applying for and receiving a discount does not mean that my Medical Services are free and that I am responsible for remaining balances."

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

☐ Patient declined to complete_____

Verified by:_____ Date:___/___/_____ Category: __A __B __C __D __E

DELHI RURAL HEALTH CLINIC
RICHLAND PARISH HOSPITAL-DELHI
SLIDING FEE SCALE
2020

FAMILY SIZE	A. $20 Minimum Pay			B. Patient Owes 25% of Charge			C. Patient Owes 50% of Charge			D. Patient Owes 75% of Charge			E. Patient Owes 100% of Charge	
1	$0	TO	$12,760	$12,761	TO	$19,140	$19,141	TO	$22,330	$22,331	TO	$25,520	over	$25,520
2	$0	TO	$17,240	$17,241	TO	$25,860	$25,861	TO	$30,170	$30,171	TO	$34,480	over	$34,480
3	$0	TO	$21,720	$21,721	TO	$32,580	$32,581	TO	$38,010	$38,011	TO	$43,440	over	$43,440
4	$0	TO	$26,200	$26,201	TO	$39,300	$39,301	TO	$45,850	$45,851	TO	$52,400	over	$52,400
5	$0	TO	$30,680	$30,681	TO	$46,020	$46,021	TO	$53,690	$53,691	TO	$61,360	over	$61,360
6	$0	TO	$35,160	$35,161	TO	$52,740	$52,741	TO	$61,530	$61,531	TO	$70,320	over	$70,320
7	$0	TO	$39,640	$39,641	TO	$59,460	$59,461	TO	$69,370	$69,371	TO	$79,280	over	$79,280
8	$0	TO	$44,120	$44,121	TO	$66,180	$66,181	TO	$77,210	$77,211	TO	$88,240	over	$88,240
9	$0	TO	$48,600	$48,601	TO	$72,900	$72,901	TO	$85,050	$85,051	TO	$97,200	over	$97,200
10	$0	TO	$53,080	$53,081	TO	$79,620	$79,621	TO	$92,890	$92,891	TO	$106,160	over	$106,160

***One or more of the following financial documents will be required when applying:

A copy of most recent income ta (preferred)
A copy of W-2 witholding forms
A copy of last 4 check stubs
Unemployment or workman's compensation
Current Bank Statement

Sliding scale applies to services performed at the Rural Health Clinic as well as outpatient services provided by the Richland Parish Hospital.

If interested, please contact our Patient Assistance Department @ (318) 878-6218