Sliding Scale Discount Program

Mosaic Medical's mission is to improve the health and well-being of the individuals, families, and communities we serve who are at or below 200 percent of the Federal Poverty Guidelines. We believe in quality care for all and strive to minimize financial barriers for our patients when it comes to receiving healthcare. Mosaic offers a Sliding Scale discount program to all patients regardless if they are insured, uninsured, or under-insured patients. If eligible for our Sliding Scale discount program, you may qualify for free or reduced healthcare, even if you currently have health insurance.

What does the Sliding Scale discount program cover?

Our Sliding Scale discount program applies to all programs and services at Mosaic Medical. Whether it is medical, dental, or mental health related you will be covered. Patients who are eligible for the Sliding Scale discount program will pay the determined fee based on their eligibility category. Different programs may have different fee schedules. The Sliding Scale discount program remains in place for one year.

If approved we request that you report any changes of income, address, and/or contact information within 10 days of the change to the billing department by calling 541-617-5369.

What is required to apply for the Sliding Scale discount program?

- Provide current proof of household *gross* income
  - Required for anyone living in the household that is over the age of 18 years old.
- Complete, sign, and date application
- Return application

You have several options available on how to return your completed application for review. The Sliding Scale discount program application and all required documentation can be:

1. Returned to the Mosaic Medical clinic you were seen at
2. Mailed to: Mosaic Medical 600 SW Columbia Drive Bend, OR 97702
3. Faxed to: 541-383-1883

If you need assistance completing the Sliding Scale discount program application or if you have any questions or concerns, please contact Customer Service at 541-383-3005.

By returning this application you have provided Mosaic Medical consent to verify the information you have provided. If your application is complete, it will be reviewed to determine eligibility. We will notify you if additional information is required to process your application. You will be notified of the status within 14 calendar days of receipt.

MosaicMedical
Quality Care For All

Proof of Income Documentation

Patients who choose to participate in the Sliding Scale discount program are required to provide proof of income. Refer to the list below and provide the most recent documentation for all income situations that apply.

****If you declare no income – you must attach a statement explaining how you sustain yourself****

Accepted Tax Returns • 1040 • 1040A • 1040EZ • 1040 NR • SSA-1099 • W-2	You can obtain a copy of your most recent tax return by calling the IRS at (800)829-1040 or online at http://www.irs.gov/individuals/Get-Transcript. If you do not file taxes, you will be asked to provide an explanation as to why.
Salary/Wages	3 consecutive months of paycheck stubs requested – minimum of 1 month required. Must be most recent paycheck stubs. **OR** If unable to provide 3 consecutive months of paycheck stubs – minimum of 1 month required – provide a letter from your employer.
Social Security Disability **Social Security Retirement** **Supplemental Security Income**	An Award letter can be obtained from the Social Security Administration by calling 1-800-772-1213. **OR** Go to the Social Security Office and request a copy.
Student Financial Aid	Go to fafsa.gov and log into your Student Aid Report (SAR) to print a copy.
Food Stamps/SNAP/TANF	An Award letter can be obtained from the local Dept. of Human Services. Bend (541) 388-6010 Redmond (541) 548-5547 Prineville (541) 447-3851 Madras (541) 475-6131 Warm Springs (541) 553-1626
Alimony/Child Support	Copy of 3 monthly checks. **OR** Court award letter indicating dollar amount and time period. **OR** Letter from the Child Support Enforcement Agency. **OR** Letter from Attorney stating amount and time period.
Housing Assistance	Contact Public Housing Authority (PHA) in Redmond (541) 923-1018.
Worker's Compensation	An Award letter or benefit statement can be obtained from the Work Compensation agency handling your claim. Will need documentation that indicates the dollar amount and time period this income is received.
Self-Employment Income	The most recent 1040 **OR** 3 consecutive months of paycheck stubs encouraged
Other	Any award letter or benefit statement; copy of 3 months of check(s), written explanation, and/or a judgment letter.

MosaicMedical
Quality Care For All

Sliding Scale Eligibility Declaration

An incomplete application is unable to be processed and will be returned to you.

Today's Date: / /				
First Name:	**Middle:**	**Last Name:**		
Physical Address:		**City:**	**State:**	**Zip:**
Mailing Address (If different than above):		**City:**	**State:**	**Zip:**
Primary Phone #:		**Other or Message Phone #:**		

List all household members. All household members over the age of 18 must disclose their income.

#	Name of Household Member	Relationship	Date of Birth	Total Gross Monthly Income	Office Use Only MRN
1		Self	/ /		
2			/ /		
3			/ /		
4			/ /		
5			/ /		
6			/ /		

Please add additional family members on back

Comments:

_____

_____

By signing below, you attest that the information you disclosed is true and correct to the best of your knowledge. The household members listed on this application are aware that their name and information have been provided. Mosaic Medical reserves the right to verify the information provided on this application and may obtain information from other sources to determine your household eligibility.

Applicant Name (please print): _____

Applicant Signature: _____ **Date:** _____

----------OFFICE USE ONLY SECTION----------

Total Annual Earnings: Effective Dates:

Employee Signature:

_____ **Date Given:** _____

Date Due: _____

Class A: B: C: D: E: **Date Received:** _____

MosaicMedical
Quality Care For All

Sliding Scale Program Patient Rights and Responsibilities

1. All patients may apply for the program whether or not you have insurance.
2. The household size is everyone in the house living off of the same financial resources. Anyone residing in household over the age of 18 is required to provide a copy of tax returns, current proof of income, or a signed statement.
3. Acceptance into the program is not guaranteed; your application will be reviewed and notification provided. If approved for the program, payment for services is due at the time of the visits.
4. We prefer patients turn in a complete application with all proof of income before receiving care. If that is not possible, applications are due within 14 calendar days. Applications received after 14 calendar days will be considered effective the date they are received. Full payment for services not covered by the program will be expected.
5. Patients may re-apply for the program at any time. Each application will be documented and the 14 calendar day requirement will re-start.
6. Not all services provided in the clinic are covered under this program. Some examples of non-covered services are:
    a. **Work related physicals-CDL's, drug screens, INS physicals**
    b. **External lab testing services (St. Charles, CORA, Central Oregon Pathology)**
7. The guarantor of this account is responsible for payments due for anyone listed on this application. If the account is sent to a collection agency, you are responsible for all collection agency account balances and fees.
8. We will not provide copies of the documents provided with this application.
9. We may need additional information to verify your income or household size.
10. Any changes to a patient's income, living arrangements, or insurance status must be shared with Mosaic Medical immediately. If Mosaic Medical is not notified of changes, patient may no longer be eligible for the program.

------PLEASE NOTE------
• Do not send in original documents; they will not be returned. • Completion of this application is not a guarantee that you will qualify for the Sliding Scale discount program. • Any outstanding balance you owe will still be your responsibility to pay. This program only applies to charges incurred once you are approved. • You will be notified of application status within 14 calendar days.

By signing below I authorize Mosaic Medical to verify the information on the application and confirm that I have read and understand the Patient Rights and Responsibilities. I also acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

_____ _____

Signature of applicant Date

_____

Printed name of applicant