

## How do I qualify?

To qualify for the Sliding Fee Discount, you MUST complete the application and provide the required documentation to show proof of annual income for all immediate family members living in your household. Gross income is ALL income from ALL sources before taxes. Applicants should provide a copy of any of the accepted income verification materials listed below along with a completed application to Del Puerto Health Care District Office.

### Accepted Income Verification

- Prior year W-2 or 1099
- Two (2) Current Paystubs
- Letter from Employer
- Form 4506-T Request for transcript of tax return (if W2 not filed)
- Self-employed - most recent three (3) months of income and expenses for the business

The patient/responsible party must complete the Sliding Fee Discount Application in its entirety. By signing the Sliding Fee Application, you authorize Del Puerto Health Care District to verify income as disclosed on the application form. Providing false information on a Sliding Fee Application will result in Sliding Fee discounts being revoked and the full balance of the account(s) restored and payable immediately.

Effective February 2017

## Contact Us

Del Puerto Health Care District

P. O. Box 187

875 E Street

Patterson, CA 95363

(209) 892-8781

[www.dphealth.org](http://www.dphealth.org)



## Patient Financial Assistance Program



## Our Values

**Compassion \* Commitment \* Excellence**

**The District's primary mission is to provide the highest quality healthcare services through the Patterson District Ambulance and Del Puerto Health Clinic while expanding the healthcare availability to the citizens of the Del Puerto Health Care District.**



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## Sliding Fee Discount Policy

At Del Puerto Health Care District, we never want cost to be a barrier to getting the health care you need. Our Financial Assistance program is designed to provide free or discounted care to those who have no means or limited means to pay for their medical services. We offer the Sliding Scale Fee Schedule to all income-eligible uninsured or under insured patients, based on their household's annual income.

No one will be denied access to services at Del Puerto Health Center or Patterson District Ambulance, as services are offered regardless of insurance status or ability to pay.

## Financial Assistance Applications

Applications may be obtained at:

Del Puerto Health Care District Office  
875 E. St  
Patterson, CA 95363

Del Puerto Health Center  
1700 Keystone Pacific Pkwy, Ste B  
Patterson, CA 95363

[www.dphealth.org](http://www.dphealth.org)

To help us determine if you qualify, please complete the Patient Financial Declaration and include all documents requested. Your application must be complete and the requested information included.

Within two weeks of submitting a complete application, you will receive a Sliding Fee Determination Letter that will explain your available discount and what new balance is due.

## Extra Prompt Pay Incentive

A 30% Prompt Pay Incentive is also available (deducting additional 30% discount from the new balance on the determination letter) **when you pay your bill in full within 30 days of the date of the Determination letter.** All patients can take advantage of the prompt pay discount.

## Eligibility

Discounts are determined by total family income and the number of family members. Family is defined as a group of two or more people ( one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered one family. Those with total family incomes at or below 100% of the poverty level will receive Health Center services a full 100% discount. Those patients with total family incomes above 100% of poverty, but at or below 200% of poverty, will be charged according to the Sliding fee Discount Schedule.

The Sliding Fee Discount Schedule is updated during the first quarter of every year with the latest Federal Poverty Guidelines.

Patterson District Ambulance patients that qualify for the maximum discount are accessed a nominal charge of \$75.00 per transport. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

All alternative payment resources must be exhausted, including all third-party payment from insurance(s), Federal and State programs.



## 2019 FINANCIAL ASSISTANCE PROGRAM DETAILS

### Financial Assistance Available

The Del Puerto Health Care District (DPHCD), which operates Patterson District Ambulance and Del Puerto Health Center recognizes medical care is costly and where ever possible we want to help the people we serve. Based on your family annual income DPHCD can provide a discount to your ambulance service charges, co-pay, and co-insurance.

### Sliding Fee Discount

Discounts are determined by total household gross income and number of family members. Family is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Charges will be adjusted based on the current Federal Poverty Level scale according to number of people in your family and gross income. Please include all income as noted on the enclosed application.

2019 Federal Poverty Levels	100%	200%	300%	400%
1 in family	\$ 12,490	\$ 24,980	\$ 37,470	\$ 49,960
2	\$ 16,910	\$ 33,820	\$ 50,730	\$ 67,640
3	\$ 21,330	\$ 42,660	\$ 63,990	\$ 85,320
4	\$ 25,750	\$ 51,500	\$ 77,250	\$ 103,000
5	\$ 30,170	\$ 60,340	\$ 90,510	\$ 120,680
6	\$ 34,590	\$ 69,180	\$ 103,770	\$ 138,360
7	\$ 39,010	\$ 78,020	\$ 117,030	\$ 156,040
8 in family	\$ 43,430	\$ 86,860	\$ 130,290	\$ 173,720
<i>each additional person, add</i>	\$ 4,420	\$ 8,840	\$ 13,260	\$ 17,680
<b>% of Federal Poverty Level</b>	<b>100%</b>	<b>200%</b>	<b>300%</b>	<b>400%</b>

Based on your family size & gross income on the Federal Poverty Level scale, the following discounts are allowed on the patient balance, excluding Medi-Cal Share of Cost.

FPL Range	Ambulance Discount	Health Center Discount
100% or less of FPL	\$100 nominal fee	\$15 nominal fee
101-200% of FPL	-90%	-80%
201-300% of FPL	-75%	-60%
301-400% of FPL	-60%	-40%

### Application Required

To help us determine if you qualify for assistance, please complete the attached Patient Financial Declaration and return with proof of income documents.

### Discount Determination Letter

Within two weeks you will receive a *Sliding Fee Determination* letter that will explain your available discount and the new balance due. Your Determination letter is valid for both Health Center and Ambulance bills.

### Extra Prompt Pay Incentive

Additionally, a 30% Prompt Pay Incentive is available (deducted from your Sliding Fee Discounted total) when you pay your bill within 30 days of the date of the Determination letter. All patients can take advantage of the prompt pay discount.

If you have questions, please do not hesitate to contact us at (209) 892-8781 and ask to speak to the Patient Financial Assistance. We are available to assist you 8:00 AM to 5:00 PM Monday through Friday.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410, or call (800) 795-3272 (voice), or (202) 720-6382 (TDD).