Mt. Grant General Hospital
P.O. Box 1510, First and A Streets
Hawthorne, Nevada 89415
(775) 945-2451
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Sliding Fee Scale Program

What is a Sliding Fee Scale?
It's possible you may be eligible for a discount on what you owe for services if you qualify for our sliding fee scale. The sliding fee scale is used to determine your payment responsibility for services you receive. Eligibility is based on your gross household income and household size and is calculated using federal guidelines.

How much will I have to pay?
Depending on your income level, you may owe only a percentage of your charges. For example, if you qualify for a 25% fee-scale, you will be responsible for 25% of the cost of services, receiving a 75% discount. If you have insurance, you will be responsible for 25% of the patient balance portion of the services.

How do I qualify?
Your total household income must fall within the Federal Poverty Guidelines to be eligible for the sliding fee scale. Sliding fee eligibility is based on the total family size (yourself, spouse, children under 18, and all others living in the household) and combined gross income.

Can I use the Sliding Fee Scale instead of my insurance?
No. The Sliding Fee Scale Program is to be used as a last resort. Mt. Grant General Hospital must bill your insurance. However, after your insurance has paid, the patient balance portion of your bill will be discounted if you qualify for our sliding fee scale.

How do I apply?
The sliding fee scale application must be completed and provided with the following documents.

- Proofs of income (one more of the following, if applicable):
  - ✓ Two months of consecutive pay stubs
  - ✓ IRS Form W-2
  - ✓ IRS Form 1099 and/or IRS Form 1099-R
  - ✓ IRS 1040 Tax Form from a licensed income tax preparer
  - ✓ Unemployment award letter
  - ✓ Social Security award letter (i.e. SSA-1099 or equivalent) or U.S. Treasury check
  - ✓ Support letter, also called 'Verification of No Income' (for those with no income)

- Other required documents:
  - ✓ Two most recent months of bank statements
  - ✓ Medicaid proof of denial documents for all children in the household who are under 18 years of age

Return the completed application with documentation to our Financial Representative for review and eligibility determination. Processing occurs within 10 business days. You will then be informed if you qualify and of your rate.

How long does a fee-scale last?

An expiration date will be set when you are approved. It is your responsibility to re-apply for the fee-scale each year. If not, you will be responsible for the full cost of services after it expires.

Other Important Information

- All income and insurance information must be disclosed when applying for a fee scale. Falsifying or withholding information is an abuse of the fee-scale and may result in permanent discharge from this program.
- To remain eligible for the sliding fee scale program you must remain current on your payments.
- If you are reapplying for the sliding fee scale program and you have past due balances, your account must be made current before your application is approved (financial arrangements are acceptable).
- If you cannot locate your FORM SSA-1099 and/or “YOUR BENEFIT AMOUNT” statement then you may call the Social Security Administration at 1-800-772-1213 to obtain these documents. You will have the option of speaking to a “live” person or an automated messaging system. It will take approximately ten business days to receive these documents from the Social Security Administration.
- Our Financial Representative will gladly answer any questions you may have regarding sliding fee scales or the application process.

I have other questions...

Call 775-945-2461, ext. 284.

Your Benefit Amount

BENEFICIARY'S NAME:

By law, Social Security benefits increase automatically to keep pace with inflation. When there is a period of no inflation, the law does not permit an increase in benefits. Based on the Consumer Price Index (CPI) published by the Department of Labor, there was no rise in the cost of living during the past year, so your benefit will remain the same in 2010. The CPI is the federal government's official measure used to calculate cost-of-living increases.

Please review the other important information in this mailing. You can use this letter when you need proof of your benefit amount to receive food stamps, rent subsidies, energy assistance, bank loans, or for other business.

How Much Will I Get And When?

- Your monthly amount (before deductions) is _____
- The amount we are deducting for Medicare medical insurance is $0.00
  (If you did not have Medicare as of Nov. 19, 2009, or if someone else pays your premium, we show $0.00.)
- The amount we are deducting for your Medicare prescription drug plan is $0.00
  (If you did not elect withholding as of Nov. 1, 2009, we show $0.00.)
- The amount we are deducting for voluntary federal tax withholding is $0.00
  (If you did not elect voluntary tax withholding as of Nov. 19, 2009, we show $0.00.)
- After taking any other deductions, we will deposit _____ into your bank account on Dec. 31, 2009.

FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT

2011

- PART OF YOUR SOCIAL SECURITY BENEFITS SHOWN IN BOX 5 MAY BE TAXABLE INCOME.
- SEE THE REVERSE FOR MORE INFORMATION.

Box 1. Name	Box 2. Beneficiary's Social Security Number
John Doe	455-00-1000

Box 3. Benefits Paid in 2010	Box 4. Benefits Repaid to SSA in 2010	Box 5. Net Benefits for 2010 (Box 3 minus Box 4)
6000		6000

DESCRIPTION OF AMOUNT IN BOX 3	DESCRIPTION OF AMOUNT IN BOX 4
	Box 6. Voluntary Federal Income Tax Withheld: 600
	Box 7. Address

SAMPLE

☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, and ZIP code	1 Gross distribution $	OMB No. 1545-0119 **2010** Form 1099-R	**Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.**
	2a Taxable amount $		
	2b Taxable amount not determined ☐ Total distribution ☐		**Copy C For Recipient's Records**
PAYER'S federal identification number / RECIPIENT'S identification number	3 Capital gain (included in box 2a) $	4 Federal income tax withheld $	
RECIPIENT'S name Street address (including apt. no.) City, state, and ZIP code	5 Employee contributions /Designated Roth contributions or insurance premiums $	6 Net unrealized appreciation in employer's securities $	This information is being furnished to the Internal Revenue Service.
	7 Distribution code(s) IRA/ SEP/ SIMPLE ☐	8 Other $ %	
	9a Your percentage of total distribution %	9b Total employee contributions $	
1st year of desig. Roth contrib.	10 State tax withheld $ / $	11 State/Payer's state no.	12 State distribution $ / $
Account number (see instructions)	13 Local tax withheld $ / $	14 Name of locality	15 Local distribution $ / $

Form 1099-R (keep for your records) Department of the Treasury - Internal Revenue Service

Mt. Grant General Hospital / Mt. Grant Medical Building

Sliding Fee Scale Application

☐ NEW Applicant *Check one* ☐ Application Renewal

Date rec'd / By	

NOTE: To comply with federal regulations and give you a discount on our medical services, it is necessary to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income once each year, and we will notify you when it is time to do so.

First name:	MI:	Last name:	Other names:	
Home address (including P.O. Box):		City:	State:	Zip:
Phone # (home & cell):		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ In a relationship		
Applicant's employer name:				

Do you consider yourself homeless?	When did you become a NV resident (mo/yr)?	Is anybody in your household elig for Mcare? If so, who?

Household Members	NAME and SSN (including applicant)	Applied for: (circle one or both)	Date of Birth Month/Day/Year	Relationship to applicant	Insurance Coverage / Insured's Name
		Mcaid / NV Chkup			
		Mcaid / NV Chkup			
		Mcaid / NV Chkup			
		Mcaid / NV Chkup			
		Mcaid / NV Chkup			
		Mcaid / NV Chkup			
		Mcaid / NV Chkup			

Income	Gross Monthly Income	For YOU	For SPOUSE	For OTHER	Subtotal
	Gross wages, salaries, and tips				$ -
	Social security, SSI:				$ -
	Annuities, pensions, investment income:				$ -
	Veterans benefits:				$ -
	Child support & alimony:				$ -
	Welfare & other government support:				$ -
	Health Savings Acct employer contribution:				$ -
	TOTAL GROSS MONTHLY INCOME -->				$ -

Proof of Income Provided		
	Gross wages, salaries, and tips:	☐ 1099 ☐ W-2 ☐ Paycheck stubs ☐ Bank statement
	Social security, SSI:	☐ SSA-1099 ☐ US Treasury check ☐ 1099-R
	Annuities, pensions, investment income:	☐ IRS Form 1040
	Veterans benefits:	
	Child support & alimony:	☐ Proof of child support / alimony
	Welfare & other government support:	☐ Unemployment letter ☐ Verification of no income letter ☐ Food Stamps
	Health Savings Acct employer contribution:	☐ HSA Bank statement ☐ Other

Collection Manager Notes

I authorize Mt. Grant General Hospital to verify all information on this application. The information provided is true to the best of my knowledge and any false information will be grounds for denial into the Sliding Fee Scale Program.

IMPORTANT
SIGN and DATE

Applicant signature **Date signed**

Hospital Administrator's Determination

☐ Application approved Family size: Eligible monthly gross income: $0.00

☐ Application denied Current uninsured MGGH balance:

Administrator signature: _____ *Date signed* *SFS expiration date*

Patient Pays
☐ 0%
☐ 25%
☐ 50%
☐ 75%
☐ Uninsured ☐ After ins pays

Date Mcare Verified	Add'l Information Needed	Date requested / By	Date Received / By	*Date Submitted to Administrator for Determination*
Date MCaid Verified				

Notes for the Hospital Administrator