

**Squirrel Hill Health Center  
Application for Financial Assistance Instructions**

It is the Squirrel Hill Health Center’s goal to provide medical care to patients regardless of their insurance status. In order to achieve this goal, the Squirrel Hill Health Center (SHHC) offers a Sliding Payment Scale to assist uninsured and underinsured patients.

Sliding Payment Scale eligibility is determined based on Federal Poverty Guidelines for household size and pre-tax income. SHHC offers financial assistance to patients who have a household income up to 200% of Federal Poverty Guidelines for 2010. These limits are listed below:

Household Size	1	2	3	4	5	6	7	8
Income	\$ 21,780	\$ 29,420	\$37,060	\$ 44,700	\$ 52,340	\$ 59,980	\$ 67,620	\$ 75,260

Any patient who meets the income guidelines can apply for the Sliding Payment Scale. If a patient is insured, SHHC must submit all charges to insurance first. The Sliding Payment Scale can then be applied to any balance due after the insurance company has processed the charges and determined the patient’s responsibility.

Children are eligible for the Sliding Scale only if they are ineligible or have been denied for Medical Assistance and Chip coverage. If parents need help applying for Medical Assistance or Chip coverage, SHHC will refer them to an agency that can help them through that process.

The Sliding Payment Scale applies exclusively to the Squirrel Hill Health Center services and providers. If you have bills at other facilities, or are concerned that you may be billed for services outside SHHC, please make an appointment with the case managers to discuss all discount program options. The case managers can often assist patients in applying for discounts on prescriptions and on services at other facilities. There is no charge to see the case managers or the financial counselor.

Patients who do not qualify for a discount, or who still have a balance due after the Sliding Payment Scale is applied are eligible for an interest free payment plan. Patients interested in a payment plan must contact the financial counselor to arrange a payment plan.

Patients have 30 days following their first appointment to complete the application and provide the requested documents. If you cannot supply the documents within 30 days of your first appointment, you must contact the financial counselor for an extension. If the documents are not received and an extension was not requested or has expired, you will be responsible for the full balance due.

**During the application process, you are required to make a minimum payment of \$15.00 per each appointment. \$15.00 is not the actual cost of the visit; it is a minimum courtesy charge while you are applying for the Sliding Payment Scale. In the event you are denied a discount or do not complete the application process, you will be responsible for the full balance due.**

**Return the information to:**

Squirrel Hill Health Center  
Attn: Financial Counselor  
200 JHF Drive, Lower Level  
Pittsburgh PA 15217

**Important phone numbers:**

Appointments 412-422-7442  
Financial counselor 412-904-5281  
Fax number 412-904-5025



**Household information, cont'd:**

Which services/benefits have you or someone in your household applied for, and have you received them or been denied?

	Applied	Denied	Received, date, monthly amount?
Medical Assistance	_____	_____	_____
Unemployment	_____	_____	_____
Social security	_____	_____	_____
Disability	_____	_____	_____
Worker's Comp	_____	_____	_____
Child support	_____	_____	_____
Alimony	_____	_____	_____
Food stamps	_____	_____	_____
Public assistance (welfare)	_____	_____	_____
Other benefits	_____	_____	_____

Do you have outstanding bills from another doctor or hospital?      No      Yes

If yes, where are bills from? \_\_\_\_\_

Squirrel Hill Health Center can not help you with payment due to other facilities. However, we will refer you to programs that may be able to help.

**All information and documents supplied to SHHC and/or disclosed to the financial counselor are confidential. Your information will not be shared with any person or agency outside of the Squirrel Hill Health Center, unless the patient gives written permission to release the information.**

**How the Sliding Payment Scale works\***

The chart below shows the balance due for several visit types at the different Sliding Scale levels.

Amounts in the grey columns are eligible for an interest free, monthly payment plan.

Type of visit:	Full Price	Full Discount	80% Discount	60% Discount	40% Discount	20% Discount	Ineligible	Fail to complete
New patient physical, 18-39 yo	\$128.00	\$15.00	\$25.60	\$51.20	\$76.80	\$102.40	\$128.00	\$128.00
New patient sick	\$104.00	\$15.00	\$20.80	\$41.60	\$62.40	\$83.20	\$104.00	\$104.00
New patient psychiatry visit	\$160.00	\$15.00	\$32.00	\$64.00	\$96.00	\$128.00	\$160.00	\$160.00
Prenatal	\$184.00	\$15.00	\$36.80	\$73.60	\$110.40	\$147.20	\$184.00	\$184.00
Basic lab panel	\$129.60	\$15.00	\$25.92	\$51.84	\$77.76	\$103.68	\$129.60	\$129.60

**\*Please note this chart provides estimates only. Additional fees and charges may apply.**

**Patients who fail to complete the application process are NOT eligible for a payment plan and may not be seen until full payment is made or until they complete the application process.**

By signing below, I certify that I have read and understand all instructions relating to this application. I understand that if I do not comply with these instructions, I will be responsible for the full balance due. I understand that completion of this application does not guarantee any discount will be granted.

By signing below, I agree that SHHC may request a copy of my credit report. I understand more information may be requested before my eligibility can be determined.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete, or false information that I provide or someone else provides for me could cancel my application for financial assistance.

All adult household members who sign below authorize the release of any medical, financial, or employment information which relates directly to their health care or financial assistance eligibility. This information may be released to any health care providers with whom SHHC is working to secure ancillary medical services on behalf of the patient. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures may not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application. For example, insurance payments, government program payments, award from a lawsuit, or any other payment.

If I receive financial assistance, I agree to alert the Squirrel Hill Health Center of any changes which could impact eligibility, including changes to family size, income, and health insurance coverage. I understand if my/our medical situation changes so that I/we may be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date

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