SOUTHERN INDIANA Community Health Care

PAOLI • MARENGO • WEST BADEN • ENGLISH • SALEM • BEDFORD • MITCHELL

COMMUNITY HEALTH ASSISTANCE PROGRAM (CHAP)

This Application is Optional

Since 1975, Southern Indiana Community Health Care has offered financial assistance to anyone who is having difficulty paying for healthcare, and as a federally qualified community health center, we will not deny services to anyone based on their ability to pay.

SICHC's Community Health Assistance Program (CHAP) offers a sliding fee discount for qualifying patients whose income and family size is below 200% of the federal poverty guidelines.

CHAP Benefits

- Discount for office visits at any SICHC location including a school-based health center or a school-based telehealth visit
- Discount for lab services
- Eligible for paid transportation vouchers from Blue River Transit Services and Orange County Transit to any SICHC location
- More than Money Program – trade volunteer hours in the community for $15 toward any SICHC charges

If you have any questions, please contact Patient Accounts at (812) 723-7121.

Southern Indiana Community Health Care — **Effective 1/11/2024**

Sliding Fee Discount Schedule

Medical & Behavioral Health Services

Annual / Yearly Income Levels

Family Size	Class 1 0 - 100% Pays Nominal Fee $15	Class 2 101 - 125% 30% Payment	Class 3 126 - 150% 40% Payment	Class 4 151 - 175% 50% Payment	Class 5 176 - 200% 60% Payment
1	$ 15,060	$ 15,061 to $ 18,825	$ 18,826 to $ 22,590	$ 22,591 to $ 26,355	$ 26,356 to $ 30,120
2	$ 20,440	$ 20,441 to $ 25,550	$ 25,551 to $ 30,660	$ 30,661 to $ 35,770	$ 35,771 to $ 40,880
3	$ 25,820	$ 25,821 to $ 32,275	$ 32,276 to $ 38,730	$ 38,731 to $ 45,185	$ 45,186 to $ 51,640
4	$ 31,200	$ 31,201 to $ 39,000	$ 39,001 to $ 46,800	$ 46,801 to $ 54,600	$ 54,601 to $ 62,400
5	$ 36,580	$ 36,581 to $ 45,725	$ 45,726 to $ 54,870	$ 54,871 to $ 64,015	$ 64,016 to $ 73,160
6	$ 41,960	$ 41,961 to $ 52,450	$ 52,451 to $ 62,940	$ 62,941 to $ 73,430	$ 73,431 to $ 83,920
7	$ 47,300	$ 47,301 to $ 59,125	$ 59,126 to $ 70,950	$ 70,951 to $ 82,775	$ 82,776 to $ 94,600
8	$ 52,720	$ 52,721 to $ 65,900	$ 65,901 to $ 79,080	$ 79,081 to $ 92,260	$ 92,261 to $ 105,440
9	$ 58,100	$ 58,101 to $ 72,625	$ 72,626 to $ 87,150	$ 87,151 to $ 101,675	$ 101,676 to $ 116,200
10	$ 63,480	$ 63,481 to $ 79,350	$ 79,351 to $ 95,220	$ 95,221 to $ 111,090	$ 111,091 to $ 126,960

- For family units of more than ten members, add $4,540 for each additional member.
- For families with income exceeding 200% of the federal poverty level, no discount is available.
- For families living at or under 100% of the poverty level, as defined by the federal guidelines, will be charged a nominal fee for medical visits.
- The medical & behavioral health sliding fee discount schedule does not apply to immunizations (with exception to the flu vaccine), injections and supplies.
- The sliding fee discount schedule does not apply to the supply costs of implantable birth control methods.

Application Number: _____

Patient Name	If patient is a minor, Guarantor Name
Patient Date of Birth	Phone Number

BELOW, LIST THOSE FAMILY MEMBERS ARE INCLUDED IN YOUR HOUSEHOLD:

Family is defined as an individual or a group of two people or more related by birth, adoption, marriage and residing together.

Name of Family Member	Relationship	Social Security #	Date of Birth	SICHC Patient	Income	Insurance
1.				Y N	Y N	Y N
2.				Y N	Y N	Y N
3.				Y N	Y N	Y N
4.				Y N	Y N	Y N
5.				Y N	Y N	Y N
6.				Y N	Y N	Y N
7.				Y N	Y N	Y N

Is anyone listed on this application pregnant? ☐ Yes ☐ No

Does anyone need assistance with Transportation? ☐ Yes ☐ No

Does anyone need assistance with Dental care? ☐ Yes ☐ No

Has patient applied for Medicaid or Insurance in the past 30 days? ☐ Yes / Date_____ ☐ No

Please provide one of the following

☐ **Federal income tax return for the individuals listed above**
(www.irs.gov to get a copy of most recent tax return)

☐ **Self-Declaration of Income Form for all individuals listed above**
(located on the back of this application)

You will have **30 days** to provide all the required information/documentation. If you do not provide *ALL* the information/documents, the CHAP Application will be *DENIED.* This means that the applicant and all household members will pay in full, until the required information/documents are received and a new CHAP application is completed.

I certify the information shown above is accurate and true. I understand that if I have provided false information, my account will default to the full amount due for services rendered. I also understand that this application is valid until the following April 30th, after which time, I will be asked to update my information.

Applicant's Signature_____ Date: _____

SELF-DECLARATION OF INCOME FORM

This form in required ONLY if a federal income tax return is not available to support the income of those individuals listed on page one.

Below, provide the annual income for all family members over 19 years of age who are listed on page one and answer the following questions.

Name					
Wages & Tips					
Social Security					
Pensions & Annuities					
Veteran Payments					
Unemployment					
Workers Compensation					
Self-Employment					
Interest & Dividends					
Rental Income					
Child Support/Alimony					
Other Income:					
Total					

1. **What is the reason you did not file taxes? (ex: religious, didn't make enough income, etc.)**

   _____

2. **Approximately how much income has come in over the last 6 months?** _____

☐ **Please provide documentation to prove this. (ex. Check stubs, social security pension, annuity income, child support, etc.)**

3. **Has there been any changes in the household or the household income recently?**

☐ **Yes** ☐ **No** **If so, what are the changes that have affected you and your household?**

_____

_____

I declare that the income information above is correct and accurately reflects my financial position. I am aware that providing false information will result in all discounts within the sliding fee discount program being revoked and the full balance of the accounts restored.

Signature: _____ Date _____

FOR OFFICE USE ONLY

SICHC Employee Application Acceptance _____ **Date:** _____

SICHC Application Review & Approval _____ **Date:** _____

Number of Members In Household	
Annual Income	

Discount Approved	**Class 1**	**Class 2**	**Class 3**	**Class 4**	**Class 5**
	Nominal Fee	**Pay 30%**	**Pay 40%**	**Pay 50%**	**Pay 60%**
Application Expiration Date:					