Quality care is affordable care.

Our Sliding Fee Discount can help to make the care you and your family get at Prism Health North Texas (PHNTX) more affordable. The number of people in your household, your HIV status, and your yearly household earnings decide how much your discount will be.

What services does the Sliding Fee Discount cover?

The Sliding Fee Discounts lower the cost of many PHNTX services, such as:

- One-on-one and group counseling sessions
- Visits with your primary care provider and dentist
- Labs (blood tests)*
- Your prescription meds*
  **some restrictions apply*

The Sliding Fee Discount will not lower the cost of services from other providers, such as:

- Some lab tests
- Certain prescription meds

How much money can I make and still get the Sliding Fee Discount?

- If you are not living with HIV, your total yearly earnings must be less than 200% of, or two times, the federal poverty guidelines.

What are the federal poverty guidelines?

Many government programs that lower the cost of healthcare have earnings limits. People who make more than the limit cannot use these programs. Each year the U.S. government sets these limits, which they call the federal poverty guidelines.

What happens if my family size or earnings change?

PHNTX will review your discount with you every six months, or any time your earnings or the size of your family changes. You will need to share proof of your current earnings with PHNTX every six months.

What if my HIV status changes?

If you have tested positive for HIV, additional resources may be available to you. Please ask to speak with a financial counselor and they will update your file, review discounts and funding that can help to pay for your care. Also, please let make sure to let staff know if your HIV status changes so that they may explain funding options with you.

APPLICATION

Your answers to the questions on this form will help us figure out how much of a discount you can get for our services.

<table>
<tr><td colspan="2"></td><td colspan="2">Today's Date: / /</td></tr>
<tr><td colspan="2">What should we call you? First Name:</td><td colspan="2">Last Name:</td></tr>
<tr><td colspan="2">Legal Name (Required) First Name:</td><td colspan="2">Middle Initial: Last Name:</td></tr>
<tr><td colspan="2">Date of Birth (MM/DD/YYYY):</td><td colspan="2">Social Security Number:</td></tr>
<tr><td colspan="2">Do you have health insurance?
☐ Yes ☐ No</td><td colspan="2">Marital Status:
☐ Single ☐ In a relationship ☐ Married
☐ Divorced ☐ Separated/Widowed</td></tr>
<tr><td colspan="3">(Mailing Address) Street Address:</td><td>Apt Number:</td></tr>
<tr><td colspan="2">City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="2">My housing is: ☐ Permanent ☐ Temporary
☐ I am experiencing homelessness</td><td colspan="2">We believe it is important to communicate with you, PHNTX may send mail to the address listed above.</td></tr>
<tr><td colspan="2">Phone Number
Cell: _____
Home: _____
Work: _____</td><td colspan="2">Patient Portal
The most secure way to communicate with us is through our patient portal. Please show us your identification and provide us with your email address to get access.
Email: _____</td></tr>
<tr><td>Gender Identity:
☐ Man
☐ Woman
☐ Trans Man
☐ Trans Woman
☐ Genderqueer/Non-Binary
☐ _____</td><td>Sex according to legal documents:
☐ Male
☐ Female
☐ Intersex
☐ _____
Do you identify as transgender?
☐ Yes ☐ No</td><td>Gender Pronouns:
☐ He/Him/His
☐ She/Her/Hers
☐ They/Them/Theirs
☐ _____</td><td>Sexual Orientation:
☐ Lesbian, Gay, Homosexual
☐ Straight, Heterosexual
☐ Bisexual
☐ Queer
☐ _____</td></tr>
</table>

Household Information

The number of people in your "household" will help us figure out how much your discount will be.

People in your "household" include:

- Legal children (under 18)
- A civil union partner
- A married spouse (husband or wife)
- Legal dependents (qualifying child or qualifying relative)

Use the chart below to list all the people in your household.

	Name of Individuals Living in the Household (including yourself)	Date of Birth	Relation to You
	Example: Jeff Smith	01/01/09	Son
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Count the number of people that you wrote down in the chart above and write that number here: ☐

Yearly Household Earnings

Your Yearly Household Earnings are the money that you and the people in your household get each year.

In the chart below:

1. Write the dollar amount of ALL earnings that you and the people in your household get each year in the Amount column.
2. Add all the numbers in the Amount column together. This number is your Total Yearly Earnings.
3. Write your Total Yearly Earnings in the box next to the arrow.

Type of Income	Amount
Salary/wages earned before taxes	
Income from business, self-employment income, and dependents	
Child support/spousal support	
Retirement or pension, veteran's payments, survivor benefits	
Social Security (SSDI/SSA)	
Unemployment	
Worker's Compensation	
Interest from savings/trusts/estates, dividends from investments, rental income	
Seasonal employment income	
Any other source of money your family uses to live on	
Total Yearly Earnings →	**$**

This is your Total Yearly Earnings. You will need this number later when you use the Sliding Fee Discount Calculator.

Note: You will need to provide copies of tax returns, pay stubs, or documents confirming earnings for all the people in your household before we approve your discount. You have 14 Days from the date of your application to provide earning documentation or your application will be denied. For your convenience, you can email your application and supporting financial documents to sfsdocs@prismntx.org

Legal Name (Print) _____

Legal Name Signature _____ Date _____

Chosen Name (Print) _____

Chosen Name Signature _____ Date _____

PLEASE NOTE: You have 14 Days from the date of your application to provide earning documentation or your application will be denied, and you will be responsible for all claims at the full Self Pay Rate. For your convenience, you can email your application and supporting financial documents to sfsdocs@prismntx.org

Declaration of Income

I, _____, (Legal name) swear or affirm that the information below is true. I understand that my income includes all money that I get from work, even if I do not report that work for tax purposes. My income also includes, but is not limited to, money I get from:

- Retirement
- Investments
- Unemployment
- Disability
- My spouse's income (if married)
- My parents' income (only considered if dependent is under 18)

My yearly income is: $ _____

☐ I do not have any documents to verify my income. The reasons are (check all that apply):

- ☐ I get paid in cash.
- ☐ I do not get pay checks or pay stubs.
- ☐ I did not file a tax return last year.
- ☐ I cannot get a letter from my employer.
- ☐ Other, please explain: _____

_____

_____

_____

☐ I currently in Texas. The address I have is my current address.

Legal Name (Print) _____

Legal Name Signature _____ Date _____

Chosen Name (Print) _____

Chosen Name Signature _____ Date _____

FOR OFFICE USE ONLY

Approved? ☐ Yes ☐ No

Documents Provided: ☐ Copies of Tax Returns ☐ Pay Stubs ☐ Other documents confirming earnings

Level of Determination: _____

Signature _____

Federal Poverty Levels 2023

People in Family/Household	< 100%	101 – 132%	133 – 174%	1175 – 200%	> 200%
1	$0 - $14,580	$14,581 - $19,390	$19,391 - $25,514	$25,515 - $29,159	$29,160 or more
2	$0 - $19,720	$19,721 - $26,227	$26,228 - $34,509	$34,510 - $39,439	$39,440 or more
3	$0 - $24,860	$24,861 - $33,063	$33,064 - $43,504	$43,505 - $49,719	$49,720 or more
4	$0 - $30,000	$30,001 - $39,899	$39,990 - $52,499	$52,500 - $59,999	$60,000 or more
5	$0 - $35,140	$35,141 - $46,735	$46,736 - $61,494	$61,495 - $70,279	$70,280 or more

Note: For families/households with more than five persons, add $5,140 for each additional person.

Sliding Fee Rates

For people not living with HIV or do not know their HIV status:

Federal Poverty Level	Medical Visit	Psychiatry Visit	Counseling Visit	Preventative Dental Visit[1]	Other Dental Visit[1]	Pharmacy Fee[2]
< 100%	$60	$60	$20	$100	$125	$0
101 – 132%	$80	$80	$40	$120	$150	75% Discount
133 – 174%	$135	$135	$80	$140	$175	50% Discount
175 – 200%	$190	$190	$100	$160	$200	25% Discount
> 200%	**No Discount[4]**	**No Discount[4]**	**No Discount[4]**	**No Discount[4]**	**No Discount[4]**	**No Discount[4]**

[1] Preventive Dental Visits include basic cleanings, exams, & x-rays. Other Dental Visits include any dental services outside of Preventive Dental Visits.

[2] Eligible medications are only those included in the PHNTX-approved medication list. If a medication on this list is available through another patient assistance program, you must use that assistance program before using PHNTX support. Sliding fee discounts only include administrative and distributing fees. You are responsible for the cost of the medication.

[3] Does not include the laboratory costs. Patients above 200% of the FPL are responsible for laboratory bills directly.

[4] Prompt Pay Discount (40% of Total Charges) available with full payment at date of appointment or within 14 days of date of appointment.