CHEMED
CENTER FOR HEALTH EDUCATION MEDICINE & DENTISTRY

1771 Madison Ave. Lakewood, NJ 08701 732-364-2144 Ext 323

Sliding Scale Rates

Scale Level	A	B	C	D	E	F**
Behavioral Health	$ 45.00	$ 50.00	$ 55.00	$ 60.00	$ 65.00	$ 100.00
Medical	$ 25.00	$ 30.00	$ 35.00	$ 40.00	$ 40.00	$ 40.00
Podiatry	$ 20.00	$ 25.00	$ 30.00	$ 35.00	$ 40.00	$ 40.00
Specialty Services*	$ 20.00	$ 25.00	$ 30.00	$ 35.00	$ 40.00	$ 40.00
Nutrition	$ 45.00	$ 50.00	$ 55.00	$ 60.00	$ 65.00	100%
Radiology	$ 45.00	$ 50.00	$ 55.00	$ 60.00	$ 65.00	100%
Mammography	$ 20.00	$ 25.00	$ 30.00	$ 35.00	$ 40.00	$ 40.00
Dental	$ 49.00	40%	50%	55%	60%	100%
Pharmacy Dispensing Fee*	$ 2.00	$ 4.00	$ 6.00	$ 8.00	$ 10.00	100%
Scale Level	**A**	**B**	**C**	**D**	**E**	**F****
Poverty level 2020	**100%**	**125%**	**150%**	**175%**	**200%**	**250%**
Family Size	**Maximum Annual Income**					
1	12,760	15,950	19,140	22,330	25,520	31,900
2	17,240	21,550	25,860	30,170	34,480	43,100
3	21,720	27,150	32,580	38,010	43,440	54,300
4	26,200	32,750	39,300	45,850	52,400	65,500
5	30,680	38,350	46,020	53,690	61,360	76,700
6	35,160	43,950	52,740	61,530	70,320	87,900
7	39,640	49,550	59,460	69,370	79,280	99,100
8	44,120	55,150	66,180	77,210	88,240	110,300
9	48,600	60,750	72,900	85,050	97,200	121,500
10	53,080	66,350	79,620	92,890	106,160	132,700
11	57,560	71,950	86,340	100,730	115,120	143,900
12	62,040	77,550	93,060	108,570	124,080	155,100
13	66,520	83,150	99,780	116,410	133,040	166,300
14	71,000	88,750	106,500	124,250	142,000	177,500
each individual	**$ 4,480.00**	**$ 5,600.00**	**$ 6,720.00**	**$ 7,840.00**	**$ 8,960.00**	**$11,200.00**

* Not included above are direct costs for pharmaceuticals, IUD's which will be the responsibility of the patient.

** The NJ Aid discount program for income levels 200%-250% and is only available for NJ Residents.

Slide Fee Discount Program

Thank you for visiting CHEMED.

Your payment may not cover the cost of your visit. $20 will be required for a medical/behavioral health visit and $49 will be required for a dental visit.

In order to determine the correct cost of today's visit, the Slide application must be completed at the CHEMED Financial Assistance office within 7 days.

To be completed at CHEMED by: _____

Failure to complete the application within 7 days will result in you becoming financially responsible for the full, unreduced cost of the visit.

The **SLIDING FEE DISCOUNT** is a Community Health Center program based on family size and gross income.

All health center patients can apply for the sliding fee discount program.

To apply for the **Slide** the Patient must complete an application form and submit: One form of ID for each household member, one Proof of Income and one Proof of Address.

The slide application must be renewed every 12 months.

PROOF OF INCOME:

Current Pay stubs (last 4 weeks of pay)

OTHER FORMS OF INCOME:

Self Employed:	Previous year 1099 income tax statement
Social Security Benefits:	Most recent award letter
Unemployment benefits:	Last 4 Stubs or unemployment confirmation of benefits letter
Pension:	Most recent statement of receipt within 12 months
Cash income / no Income:	Letter from Employer
	Self-Attestation
	Letter from Supporter with Supporters ID
Rental income:	Previous year 1040 income Tax return statement
	Rental lease or Self-Attestation
Investment Income:	Previous year 1040 income Tax return statement
	Bank statement or self-attestation
Full time Student:	Letter from School stating full time student and whether or not scholarship is received.

The application should be completed and signed by an adult household-member at the Financial Assistance Department at CHEMED.

IDENTIFICATION

One form of ID is required for each member listed on the application

Accepted forms of ID:

Valid photo Driver's License**

Valid Passport

Birth Certificate

Social Security Cards

Alien Registration Card, Green Card (date of entry must be legible)

Newborn (up to 3 weeks): Hospital crib card or the Hospital Certificate is sufficient.

**if using this as photo ID this cannot be used as proof of residence

PROOF OF RESIDENCE

Utility Bill (gas, electrical, water or phone bill addressed to you one month prior to date of service)

Previous month Bank Statement

Car Registration/ Auto Insurance

Rental Lease/ Mortgage Statement

MARRIAGE CERTIFICATE REQUIRED (if applicable)

CHEMED Financial Assistance Department

Hours of Operation: (subject to change)

Monday - Thursday:	8:00AM – 9:00PM
Friday:	8:00AM – 4:00PM
Sunday:	8::00AM – 8:00PM

Contact Information:

Phone: 732 364 2144 x323

Fax: 732 523 7953

Email: financialassistance@chemedhealth.org

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Financial Assistance Application – Page 1

Applicant (Patient) Name: *(Last)* *(First)* **Application Date:**

Address: *Street, Suite* *City* *State* *Zip* **Phone #:**

CITIZENSHIP (required only for NJ LOA): **US** Citizen **G**reen Card (need date of entry) **Non** US Citizen

Marital Status: Single **M**arried **Sep**arated **D**ivorced **W**idowed

Family Size – Please list all dependents including yourself

RACE: **W**hite **A**frican American **H**ispanic **O**ther

	Last Name, First Name	GENDER	DOB (MM/DD/YYYY)	RACE	CITIZEN (NJ LOA)	MARITAL	Relationship to patient
1.							**Patient**
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Household Income

Household member receiving income (including children)	Employer Name • self-employed write "Self-employed" • Owner write "owner"	Full-time or Part-time		How often paid (check one box)					Gross income per pay period
		FT	PT	Weekly	Bi-weekly	Monthly	Semi-Monthly	Annually	
		❑	❑	❑	❑	❑	❑	❑	$
		❑	❑	❑	❑	❑	❑	❑	$
		❑	❑	❑	❑	❑	❑	❑	$

Do you or any household member receive any other source of income: $ ❑weekly ❑biweekly ❑monthly ❑semi-monthly ❑annually

Total Annual Household Income $

Is anyone in your household pregnant ❑Yes - Due Date: _____ / ____ / _____ ❑No

Do you have any of the following: ❑No ❑Private Insurance ❑Medicaid ❑NJ Family Care ❑Medicare ❑Travelers Insurance:

If yes, does it cover dental ❑Yes ❑No **Effective date:** / /

I certify that the family size and income information shown above is correct. Copies of ID for every family member, tax returns, pay stubs and other information verifying income, and proof of residency are required before a discount is approved.
I understand that based on the above information, I may not be eligible for financial assistance. I understand that I may be required to follow up to qualify for financial assistance. If I am not eligible for financial assistance, I understand that I will be held responsible for the balance on my account(s).
Please note that direct costs, such as IUD's and pharmaceuticals may not be covered under the sliding fee.

Print Patient or Guardian Name ***Signature of Patient or Guardian*** *Date*

-- OFFICE USE ONLY --

Patient approved for: ❑Plan A ❑Plan B ❑Plan C ❑Plan D ❑ Plan E ❑ Plan F (NJ LOA)

Approved and verified by (Print) | Staff Signature | Date | Valid until

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Financial Assistance Application – Page 2

Date: / / _____ Patient Last Name _____ Patient First Name

Section I: All information will be kept strictly confidential

Annual Family Income $ _____

Monthly Family Income (Divided annual by 12) $ _____

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Signature of Patient/Guardian: _____ Date _____

Signature of CHEMED Staff: _____ Date _____