HMC
HIGHLAND MEDICAL CENTER
Caring for the health of the Highlands

PO Box 490, 120 Jackson River Rd., Monterey VA 24465
Ph: (540)468-6400 Fax: (540) 468-3301

Beginning January 1, 2019 more adults living in Virginia became eligible for Medicaid. Even if you have applied for Medicaid in the past you may be eligible now.

Below is the chart for income eligibility. If your income falls within these guidelines and you are age 19 to 64, you should apply for Medicaid and then you will be considered for discounted care at HMC.

Please provide Highland Medical Center a copy of a denial letter from Medicaid if you have applied and were denied.

FAMILY SIZE	MONTHLY	YEARLY
1	$ 1,563.00	$ 18,755.00
2	$ 2,106.00	$ 25,269.00
3	$ 2,649.00	$ 31,782.00
4	$ 3,192.00	$ 38,296.00
5	$ 3,735.00	$ 44,810.00
6	$ 4,277.00	$ 51,323.00
7	$ 4,820.00	$ 57,837.00
8	$ 5,363.00	$ 64,350.00
Add for each additional member	$ 543.00	$ 6,514.00

Here are the options on how to apply:

1. Go to your local Social Service Department
2. Fill out paper application and take to your local Social Services Department
3. Call 1-855-242-8282 - option 2 and option 2 again
4. Go on line at http://www.coverva.org/

Options 1 or 2 are the quickest way to get your application processed. Call our local social services department at 540-468-2199.

Thank you for choosing Highland Medical Center for your healthcare needs.

Sincerely,

Highland Medical Center

Highland Medical Center, Inc.
Application/Agreement for Discounted Fees

* Eligibility for discounted medical and dental fees is based on household income and number of persons in the household according to federal guidelines.
* You may qualify for the discount even if you have Medicare, Medicaid or private health insurance.
* Discounts do not apply to pharmacy, some laboratory charges and non-medical optical visit.
* You may qualify for separate programs which provide discounts on some prescription medications.
* Outside lab orders do not qualify for sliding fee discount program.
* Proof of income must be provided within 2 weeks of applying.
* **Please return completed application with financial paperwork to:**
  Highland Medical Center, Attn: Vickie Hoover, PO Box 490, Monterey VA 24465
  Tel# 540-468-6446, Fax# 540-468-3316 or vhoover@ourhmc.org

PLEASE READ THIS APPLICATION CAREFULLY. Our staff will help you to complete all requested information, if needed. You will need to bring in all required documents and this application must be approved before you will receive any discounts. There are no retroactive discounts and no discounts on amounts already owed on your account.

Applicant Name:_____

Social Security #:_____ Birthdate:_____ Sex:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone: _____ Work: _____ Cell:_____

E-mail Address: _____

If you do not have an E-mail Address, please check here: □

Marital Status: Married Single Widowed Divorced Separated (Circle One)

Veteran? _____ Yes _____ No

Health Insurance? _____ Yes _____ No

Insurance Co:_____

Dental Insurance? _____ Yes _____ No

Insurance Co:_____

I. List all household members:

Spouse:

Full Name: _____

Birth Date: _____ Covered by insurance? _____Yes _____No

Minor Child:

Full Name: _____

Birth Date: _____ Covered by insurance? _____Yes _____No

Minor Child:

Full Name: _____

Birth Date: _____ Covered by insurance? _____Yes _____No

Minor Child:

Full Name: _____

Birth Date: _____ Covered by insurance? _____Yes _____No

Minor Child:

Full Name: _____

Birth Date: _____ Covered by insurance? _____Yes _____No

List all other household members, regardless of relationship:

Others:

Full Name: _____

Relationship: _____

Birth Date: _____ Covered by insurance? _____Yes _____No

Is this person your dependent? _____Yes _____No

If you share expenses, please explain:_____

_____

Others:

Full Name: _____

Relationship: _____

Birth Date: _____ Covered by insurance? _____Yes _____No

Is this person your dependent? _____Yes _____No

If you share expenses, please explain:_____

_____

II. Household Income

You will need to provide the following documentation for these amounts: 3 most recent pay stubs for all wages and your most recently filed federal income tax return.

Monthly income of all household members:

Gross Wages: $_____ Name:_____

$_____ Name:_____

Self-Employment: $_____ Name:_____

$_____ Name:_____

Social Security: $_____ Name:_____

$_____ Name:_____

Disability: $_____ Name:_____

$_____ Name:_____

Unemployment: $_____ Name:_____

$_____ Name:_____

Public assistance: $_____ Name:_____

$_____ Name:_____

Pension/Retirement: $_____ Name:_____

$_____ Name:_____

Annuities: $_____ Name:_____

$_____ Name:_____

Interest/Dividends: $_____ Name:_____

$_____ Name:_____

Child Support: $_____ Name:_____

Alimony: $_____ Name:_____

Rental Income: $_____ Name:_____

Other Income: $_____ Name:_____

Describe: _____

If you have no income from any source, please explain who pays your bills and living expenses:

_____

_____

III. Expenses and other information:

*Health insurance premium per month which you pay: $ _____

*(This only applies to social security benefit recipients)

Please describe any other circumstances that you feel are important to this application:

_____

_____

_____

IV. Certification:

PLEASE NOTE: This application expires one year from the date of approval. It is very important for you to reapply one month prior to expiration to make sure there is no lapse in your discount.

If I am approved for discounted services, I agree to notify Highland Medical Center if my income or household size changes. I understant that if I do not pay amounts due to Highland Medical Center, measures may be taken to collect these debts, just as would non-discounted debts.

This information is true and correct to the best of my knowledge. I understand that if I give false information or fail to notify the Center if my situation changes, Highland Medical Center may deny deny me (and my family) future discounts and services.

_____ _____ _____

Applicant Signature Print Name Date

.

****

OFFICE USE ONLY:

Date Received:_____

Income Determination: $_____ Weekly Bi-Weekly Monthly Annually

Household Size Determination: _____

Comments:_____

_____

_____

Date Approved:_____ Discount Level: A B C D DNQ

Date Denied:_____

Names of all patients covered by this application:_____

_____

Date Entered Into Billing System:_____

Processed by: _____

Employee Signature

**** Discount rates, coverage and terms subject to change with 30 days written notice.***

Explanation of Required Documents for Proof of Income

*****The Sliding Scale Discount rates will not take effect until Proof of Income is provided.*****
*****Proof of Income must be provided within 2 weeks of applying*****

A copy of last year's tax return is required. If not provided, your application will not be processed.
If you did not file taxes, please sign below.

Please provide the following additional documents if you are working:

1) Copy of last 3 pay stubs

If you are self employed, a copy of your most recent tax return is required.

Please provide the following additional documents if you are retired or disabled:

1) Copy of your Social Security Benefits Statement **or**
2) Copy of your bank statement that shows your monthly deposit

If you do not have income, you will need to ask for a Self-Declaration of Income form.

I, _____, did not file taxes last year.

Sign: _____

Date: _____

HIGHLAND MEDICAL CENTER
2023-2024
MEDICAL, BEHAVIORAL HEALTH & PHYSICAL THERAPY SLIDING SCALE DISCOUNT FEES

Slide Category ------->	A		B		C		D		No Discount
% OF FEDERAL PROVERTY GUIDELINES	0 to 100%		>100 to 150%		>150 to 175%		>175 to 200%		Over 200%
FEES EXPECTED AT TIME OF VISIT --->	Medical, BH, PT: $10 fee,		Medical, BH, PT: $15 fee,		Medical, BH, PT: $20 fee,		Medical, BH, PT: $25 fee,		Pay 100% if income is Greater than or equal to:
Family Size	Income Ranges:		Income Ranges:		Income Ranges:		Income Ranges:		
1	$0	$ 14,580	$ 14,581	$ 21,870	$ 21,871	$ 25,515	$ 25,516	$ 29,160	$ 29,161
2	$0	$ 19,720	$ 19,721	$ 29,580	$ 29,581	$ 34,510	$ 34,511	$ 39,440	$ 39,441
3	$0	$ 24,860	$ 24,861	$ 37,290	$ 37,291	$ 43,505	$ 43,506	$ 49,720	$ 49,721
4	$0	$ 30,000	$ 30,001	$ 45,000	$ 45,001	$ 52,500	$ 52,501	$ 60,000	$ 60,001
5	$0	$ 35,140	$ 35,141	$ 52,710	$ 52,711	$ 61,495	$ 61,496	$ 70,280	$ 70,281
6	$0	$ 40,280	$ 40,281	$ 60,420	$ 60,421	$ 70,490	$ 70,491	$ 80,560	$ 80,561
7	$0	$ 45,420	$ 45,421	$ 68,130	$ 68,131	$ 79,485	$ 79,486	$ 90,840	$ 90,841
8	$0	$ 50,560	$ 50,561	$ 75,840	$ 75,841	$ 88,480	$ 88,481	$ 101,120	$ 101,121
For families larger than 8 add this amount for each person over 8		$ 5,140		$ 5,140		$ 5,140		$ 5,140	

Sliding scale discount fee patients will be charged a flat-rate fee for laboratory and radiology services. Non-HMC provider orders are not eligible for the discount.

Lab/Xray Fees per Service	$ -	$ 5.00	$ 10.00	$ 15.00	FULL FEE

*****All fees are to be paid at the time services are rendered*****

HIGHLAND MEDICAL CENTER
2023-2024
DENTAL SLIDING SCALE DISCOUNT FEES

Sliding Discount Fee Scale does not cover any specialty dental care such as: orthondontics, periodontal surgeries, endodontics, dental implants, biopsy, lesion removal, surgical extractions, or any other services that are referred out to a specialist.

Patients are expected to pay their copay prior to being seated for their care.

Intermediate and Complex procedure fees and 1/2 of the laboratory fee must be paid in full prior to sending castings to the laboratory for the patient-specific dental device.

Laboratory fees for the creation of a patient-specific dental device must be paid in full by the patient prior to the delivery of the dental device.

Slide Category ------->	A		B		C		D		No Discount
% OF FEDERAL PROVERTY GUIDELINES	0 to 100%		> 100 to 150%		>150 to 175%		>175 to 200%		Over 200%
FEES EXPECTED AT TIME OF VISIT --->	$15 per Preventive Service $30 per Basic Service $90 per Intermediate Service plus lab fee $270 per Complex Service plus lab fee		$20 per Preventive Service $40 per Basic Service $120 per Intermediate Service plus lab fee $360 per Complex Service plus lab fee		$25 per Preventive Service $50 per Basic Service $150 per Intermediate Service plus lab fee $450 per Complex Service plus lab fee		$30 per Preventive Service $60 per Basic Service $180 per Intermediate Service plus lab fee $540 per Complex Service plus lab fee		Pay 100% if income is Greater than or equal to:
Family Size	Income Ranges:		Income Ranges:		Income Ranges:		Income Ranges:		
1	$0	$ 14,580	$ 14,581	$ 21,870	$ 21,871	$ 25,515	$ 25,516	$ 29,160	$ 29,161
2	$0	$ 19,720	$ 19,721	$ 29,580	$ 29,581	$ 34,510	$ 34,511	$ 39,440	$ 39,441
3	$0	$ 24,860	$ 24,861	$ 37,290	$ 37,291	$ 43,505	$ 43,506	$ 49,720	$ 49,721
4	$0	$ 30,000	$ 30,001	$ 45,000	$ 45,001	$ 52,500	$ 52,501	$ 60,000	$ 60,001
5	$0	$ 35,140	$ 35,141	$ 52,710	$ 52,711	$ 61,495	$ 61,496	$ 70,280	$ 70,281
6	$0	$ 40,280	$ 40,281	$ 60,420	$ 60,421	$ 70,490	$ 70,491	$ 80,560	$ 80,561
7	$0	$ 45,420	$ 45,421	$ 68,130	$ 68,131	$ 79,485	$ 79,486	$ 90,840	$ 90,841
8	$0	$ 50,560	$ 50,561	$ 75,840	$ 75,841	$ 88,480	$ 88,481	$ 101,120	$ 101,121
For families larger than 8 add this amount for each person over 8		$ 5,140		$ 5,140		$ 5,140		$ 5,140	

Preventive: Comprehensive, periodic or limited dental exam; bitewing and/or periapical radiographs; full mouth radiograph series; panoramic Xray; routine prophylaxis; periodontal maintenance; placement of dental sealants; placement of silver diamine fluoride

Basic: Full mouth debridement; dental extraction per tooth; one dental filling per tooth; vital pulpotomy; gross pulpal debridement; direct or indirect pulp cap; diagnostic casts; cementation of crown or bridge; minor denture repair done in house; denture adjustment; adjust or removal of partial denture

Intermediate: Incision & drainage; single canal nonsurgical root canal therapy; deep cleaning of one quadrant; reline of denture or removable partial denture done in house; occlusal/night guard; repair broken denture base; replace/repair broken denture tooth-up to 3 teeth; repair cast framework; repair/replace clasp; add clasp to removable partial denture

Complex: Single unit crown; fixed partial denture per unit (bridge); removable partial denture; complete denture; reline or rebase of denture or removable partial denture sent to an outside laboratory

REV'D 02/14/22 VLH

HIGHLAND MEDICAL CENTER
2023-2024
PHARMACY SLIDING SCALE DISCOUNT DISPENSING FEES

CATEGORIES	% OF FEDERAL PROVERTY GUIDELINES	DISPENSING FEE 30-DAY FILL	DISPENSING FEE 90-DAY FILL
SLIDE A	0 to 100%	$ 1	$ 3
SLIDE B	>100 to 150%	$ 3	$ 6
SLIDE C	>150 TO 175%	$ 5	$ 9
SLIDE D	>175 to 200%	$ 8	$ 12
FULL FEE	>200%	$ 10	$ 15

(PER PRESCRIPTION)

REV'D 02/14/22 VLH