



www.jamestownmedical.com

Subject: Primary Care of Jamestown Sliding Fee Discount Program (SFDP)

Effective Date: January 1, 2025

Policy: Sliding Fee Discount Schedule for Eligible Patients

What is a Sliding Fee Discount Program?

Primary Care of Jamestown, LLC (PCOJ) serves primary care patients 2 years and up regardless of ability to pay. PCOJ offers discounts of services based on household income and family size. Primary Care of Jamestown will not deny access to service due to inability to pay, and there is a discounted/sliding fee schedule available based on family size and income upon request from reception. These notices can be found in the Front Lobby Area at check in or on our clinic website at www.jamestownmedical.com. The Sliding Fee Discount Program is available to all patients.

How can the program help you?

The PCOJ Sliding Fee Discount Program reduces your cost of services at PCOJ. Even if you have insurance but have a high deductible and/or non-covered services, the SFDP may help you pay for your health care. If you qualify for the SFDP, you have the option to waive filing insurance and use your sliding fee discount.

How do I apply?

To qualify for the sliding fee discount, you must complete an application process to establish your sliding scale fee. You must qualify for the sliding fee discount each year. You must complete an intake application and provide proof of household income that does not exceed 200% of Federal Poverty guidelines. Patients must have their account with PCOJ in good standing prior to submitting an application for the Sliding Scale Discount Program.

ITEMS NEEDED TO APPLY FOR THE SLIDING SCALE DISCOUNT PROGRAM:

1. Photo ID: Driver's License or other state issued ID
2. Proof of residence
3. Proof of income (can be provided by letter, bank statement or copy of check): *All that apply must be submitted with application.*
 - 3 current check stubs
 - Copy of most recent tax return
 - Unemployment stub
 - Pension and/or Retirement
 - Social Security
 - Disability
 - Child Support
 - SSI

How long will I stay on the Sliding Fee Discount Program?

Enrollment in the Sliding Fee Discount Program is good for one year. After one year, you will need to reapply and update your information. If you have changes during the year with your household income, household size and/or insurance coverage; please inform our Patient Service Representatives. Eligibility re-evaluations are completed 1 (one) year from the original application and a new application will need to be submitted. Patients will need to complete a new application and submit the required documentation as stated in the Policy for Sliding Scale Discount Schedule for Eligible Patients if they reapply or re-evaluated.

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Financial Policy

All copays, sliding fees or cash payment options are due at check-in. Primary Care of Jamestown accepts all Medicaid, Medicare, TennCare and most commercial insurance. Primary Care of Jamestown offers self-pay options including a SLIDING FEE DISCOUNT PROGRAM (see below for more information) or a cash payment option. Primary Care of Jamestown has an agreement to provide discounts based on income and household size for our uninsured and underinsured patients based on family size and income.

Primary Care of Jamestown understands that sometimes financial circumstances make it difficult to pay for your visit at the time of service. If you are experiencing hardship, you may need to contact our Patient Services Team at [931-879-3953](tel:931-879-3953). They will work with you to set up alternative payment arrangements. No one will be denied access to services due to inability to pay.

Primary Care of Jamestown utilizes a third-party lab for outside laboratory services and has an agreement to provide discounts based on income and household size for our uninsured and underinsured patients. Any lab fees will be billed directly from the lab.

Effective January 1, 2022

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost. Under the law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the bill for medical items and services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and medical visit charges.

Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.

Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, contact Patient Services.

Billing and Insurance Information

If you have billing and/or insurance questions, please call our office at [931-879-5864](tel:931-879-5864) and select option 7 for the Billing Department. Primary Care of Jamestown provides excellent care for everyone regardless of their insurance status. We welcome TennCare (Medicaid), CoverKids, Medicare and most commercial insurance plans in addition to a self-pay program for uninsured patients.

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931-879-5864 (Clinic)
931-879-0796 (Fax)
www.jamestownmedical.com

Clinic Address:
101 S Duncan St Suite C
Jamestown, TN 38556

Patient Payments and Unwillingness to Pay

POLICY:

Primary Care of Jamestown (PCOJ) strives to collect appropriate payments from patients. PCOJ mission is to provide access to healthcare to all regardless of a patient's ability to pay. The intent of this policy is to define "unwillingness to pay".

PCOJ definition of "Unwillingness to Pay": PCOJ distinguishes between a patient's inability to pay and a patient's unwillingness to pay. An 'unwillingness to pay' applies to patients who have not made an average of \$10 a month for an extended period of time (greater than 6 months) and/or have not met the terms of their payment plan agreements and/or furnished false information to PCOJ during the application process.

Patients who will not work with PCOJ (avoidance, repeated noncompliance of payment arrangements, averaged payments of \$10 or less per month for more than 6 months), MMC defines that as "unwillingness to pay"

PROCEDURE:

PCOJ makes reasonable efforts to collect on patient accounts utilizing the following actions; grace periods are granted throughout this process:

- Statements – 3 monthly statements are sent prior to next actions
- Courtesy calls to patients to explore and utilize patient assistance programs and resources (i.e.: creating payment plans as low as \$10/month, sliding fee eligibility, and hardship exemptions).
- Conferencing – Appointments are offered for patients to meet with Patient Services to discuss, explore and utilize patient assistance/resources.
- Financial Counselor will notify patients that services will be restricted or denied when the patient is deemed unwilling to pay. Once a patient has been deemed unwilling to pay, the patient will be dismissed from the practice and the account may be sent to collections.
- Collections - Accounts not in good standing will be referred to the collection agency. Additional fees may apply. Courtesy calls to patients to explore and utilize patient assistance programs and resources (i.e.: creating payment plans as low as \$10/month, sliding fee eligibility, and hardship exemptions) prior to this step being taken.

All patients are expected to either present proof of third party coverage for services or make some payment for services rendered at the time of service.

APPLICABILITY:

This policy applies to all patients.

Initial: _____

SLIDING FEE DISCOUNT PROGRAM APPLICATION

- A separate application is required for each member of the household who wants to participate in this program, including minor children.
- You must complete the entire application.
- If you need assistance, please contact Patient Services by visiting our office location or calling 931-879-3953.

Name: _____ Date of Birth: _____

Mailing Address: _____

Primary Phone Number: _____ Cell Number: _____

Do you have health insurance?: YES / NO If Yes, please list _____

Have you applied to Medicare/Medicaid within the last year? YES / NO

We recommend that all applicants apply to Medicare/Medicaid each year.

It is necessary for Primary Care of Jamestown to ask personal questions in order to determine if you are eligible for this program. This information will be kept on file in strict confidence. You must verify your income when you apply and once a year when your application is renewed. Copies of your yearly federal income tax return, payroll check stubs covering the past month, Social Security benefit statements or other income sources are required. We cannot use bank statements for this purpose. Your annual income and household size will be used to determine your visit fee. I declare the above information is true and give Primary Care of Jamestown permission to investigate any information in this application.

I understand that:

- My information will be held in strict confidence.
- If this information is found to be false, I will lose my eligibility for the program and be liable to repay any benefit I have received.
- If my income or household size changes, I am required to notify the Patient Services as soon as possible,
- I have six weeks to return this application complete with proof of my annual income or this application will expire.
- I may reapply to the program at any time, but reduced fees will apply only from the date of the new application.
- If I am found to be eligible for reduced fees but failed to make required payments, my account may be sent to a collection agency.

Patient Signature

Date

Parent/ Legal Guardian Signature

Date

SLIDING FEE DISCOUNT PROGRAM APPLICATION CHECKLIST

- Complete signed application for each applicant, listing all household members and income sources
- Proof of income for each income source for each adult
- If you have very low or no income, you must complete the "Zero Income Worksheet" for each adult to be considered for the program.
- Most recent federal tax return if you file taxes

HOUSEHOLD: Please list all names and dates of births for all members of your household **including yourself**.

- If you file taxes your household is you, your spouse and any dependents you claimed on your taxes.
- If you are claimed as a dependent by someone else, your household is you, the person who claims you and anyone else listed on their tax return.
- If you do not file taxes and are not claimed as a dependent by anyone else, your household is you and your spouse and children if they live with you.

INCOME: You need to provide proof of income for each of the following sources of income for each member of your household to see if you qualify. Please note that we cannot accept bank statements as proof of income.

If you have very low or no income, you must complete the Zero Income Worksheet.

Employed: Pay stubs for the last four weeks OR federal tax return

Self-employment and Rental Income: you must provide a copy of your most recent federal tax return

Current Benefit Statement for:

Unemployment | Social Security | TANF | Worker's Compensation | Long or short term disability | Child support/Alimony | Retirement pension and or annuity

First and Last Name	Relation to you	Date of Birth	Gross Income before taxes and deductions	Income Source with documents attached
	SELF		\$_____ per	
			\$_____ per	
			\$_____ per	
			\$_____ per	
			\$_____ per	

Zero Income Self Declaration Worksheet

To receive services **FREE** of Charge please complete the Self Declaration Worksheet

Application for (*person with NO income*): _____

Date of Birth: _____

I, _____ certify that I have not received any income since _____.

Place(s) of last
employment: _____.

_____ I am a full-time student over the age of 18.

Housing

I live in:

_____ My own home/apartment Do you receive housing assistance? Yes No

_____ Someone else's home/apartment Name of house/apartment owner:

_____ Shelter/Transitional housing

Other: _____

Food

Do you receive Food Stamps? _____ Yes (If Yes, you must attach a copy from DHHS.)

_____ No

Transportation

_____ I have my own vehicle

_____ A friend or relative provides me with transportation

_____ I use public transportation

Communication Expenses

Do you have a cell phone? Yes No

If Yes, who pays for your cell phone? _____

Primary Care of Jamestown

A Subsidiary of Presley Healthcare

www.jamestownmedical.com

All person(s) that have provided you with assistance in the past 3 months (monetary or non-monetary), must complete the following charts and sign below verify what assistance they have provided for you.

- If someone has given you money to pay for expenses below, indicate how much they have paid and write their name in the appropriate box.
- If someone has provided you any of the below expenses for free, please indicate free and put their name in the appropriate box.

EXAMPLE ONLY	Month	May 2017
	\$ or Free?	Who Assisted?
Housing Expenses	Free	Mom
Utilities (water/sewer/electric)	included	
Heat	included	
Food Expenses	\$189	Food stamps
Transportation Expenses	\$20	Grandma
Communication Expenses	\$40	Mom
Medical Expenses	none	
Other Expenses	none	

(Mom & Grandma would then sign form + attach food stamp letter)

Month # 1	Month	
	\$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Month # 2	Month	
	\$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Month #3	Month	
	\$ or Free?	Who Assisted?
Housing Expenses		
Utilities (water/sewer/electric)		
Heat		
Food Expenses		
Transportation Expenses		
Communication Expenses		
Medical Expenses		
Other Expenses		

Printed Name and Signature of Person(s) who provided you with assistance:

Date: _____

Date: _____

*This form must be filled out completely; we will not be able to process your application if you leave parts of it blank. If you need to tell us more about your specific situation, please feel free to attach a letter or statement to this worksheet. If you receive assistance from other agencies, (LiHeap, General Assistance etc.) please attach copies of any assistance provided to you.

I do hereby swear and attest that all the information above about me is true and correct.

Signature of Person with No Income: _____ Date: _____



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Payment Options for Primary Care of Jamestown Patients

- **Cash Rate:** If you have no insurance or choose not to file with your insurance, Primary Care of Jamestown offers a cash rate option. New Patient Office Visit rate is \$150.00. Established Patient Office Visit rate is \$100.00 (excludes Gynecology). Payment is expected at the time of service.
- **Sliding Fee Scale:** (low-income qualified patients) Primary Care of Jamestown offers a discount program based on family size and income for all patients who qualify. The cost per visit will range from \$30 to \$75 per visit. Please bring proof of household income to your first visit. If you do not bring your proof of income, you will receive our cash discount rate. Within 30 days of your self-pay application proof of income may be presented for a retro adjustment. Payment is expected at the time of service.
- **Medicaid and Medicare:** Primary Care of Jamestown accepts all Medicare and TN Medicaid.
- **Commercial:** Primary Care of Jamestown accepts most insurance plans. Patients are responsible to know if the provider they are seeing is covered under their plan. Ask the Receptionist for assistance if needed. All insurance co-payments are due at time of service.
- **Outside Lab Services:** All labs will be billed separately from Pathgroup or the lab designated by your insurance.
- **Shingles Vaccine:** Is not covered under sliding scale rates and is \$175.00
- **Covid & Flu Vaccine:** Is not covered under sliding scale rates and is \$155.00
- **Nurse Visits:** are not covered under sliding scale rates and is \$45.00

TO RECEIVE SERVICES FREE OF CHARGE, AN APPLICATION MUST BE COMPLETED ALONG WITH THE SELF DECLARATION FORM AND SUBMITTED FOR REVIEW

Initial: _____

NOTICE OF PATIENT UNDERSTANDING FOR SLIDING FEE PROGRAM

- Patients can reapply or be eligible to be re-evaluated 1 year from their completed application that was submitted. Patients will need to complete a new application and submit the required documentation as stated in the Policy for Sliding Scale Discount Schedule for Eligible Patients if they reapply or re-evaluated.
- Primary Care of Jamestown describes Income as the actual current total cash or financial support available to an individual or household, before taxes. This includes wages, unemployment and worker's compensation, self-employment earnings, and other regular or recurring sources of income. Supporting documentation like tax returns, pay stubs, and/or bank statements are used to verify income.
- Primary Care of Jamestown describes family size as the number of persons in the family who live in the same dwelling and are related to each other by blood, marriage, common-law union, adoption or a foster relationship.
- Patients can receive a full itemized breakdown of their statement by contacting the billing department.
- PCOJ has posted signage for the Sliding Fee Discount Program in the Lobby Areas and Patient Rooms of the Clinics. PUC also has applications and other information regarding the SDFP on their website www.jamestownmedical.com. No one will be denied access to service due to inability to pay, and There is a discounted/sliding fee schedule available based on family size and income.

Initial: _____



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Primary Care of Jamestown exists to provide healthcare services to everyone. We provide a sliding fee scale program for those persons meeting federal poverty guidelines. Effective January 1, 2025 MMC sliding fees were adjusted to meet the 2025 Federal Poverty Guidelines. Due to this, the fee for your category may have changed. A front desk associate will provide you with a copy of our sliding fee scale program so you are aware of the fees you may be charged at time of service.

2025 Poverty Guidelines for Using to Calculate % Sliding Fee

Poverty Level	Poverty	Up to 150% above poverty	151% up to 200% above poverty
# Living in Household	No Charge	Discount on Fees = 70%	Discount on Fees = 50%
1	\$15,650 and below	\$23,475 and below	\$23,631 - \$31,300
2	\$21,150 and below	\$31,725 and below	\$31,936 - \$42,300
3	\$26,650 and below	\$39,975 and below	\$40,241 - \$53,300
4	\$32,150 and below	\$48,225 and below	\$48,546 - \$64,300
5	\$37,650 and below	\$56,475 and below	\$56,851 - \$75,300
6	\$43,150 and below	\$64,725 and below	\$65,156 - \$86,300
7	\$48,650 and below	\$72,975 and below	\$73,461 - \$97,300
8	\$54,150 and below	\$81,225 and below	\$87,766 - \$108,300

* For a Families/households with more than 8 people, add \$5,150 for each additional person

*Scale is Based on Annual Income

PCOJ Charges for supplies such as prescription medications or medical equipment, are not included in the sliding fee discount price.

Primary Care of Jamestown leverages two factors when calculating your Sliding Fee Scale Discount: number of members of the household and income. When you apply for your Sliding Fee Scale Discount, these two factors will then be used to calculate what Slide Category you qualify for.

Sliding Fee Discounts Program for Eligible Patients Based on HOUSEHOLD INCOME and DEPENDENTS

OUTSIDE LABS WILL BE BILLED SEPARATELY FROM THE THIRD PARTY LAB

SHINGLES ARE NOT INCLUDED IN SLIDING FEE, THE COST IS \$175.00

NURSE VISIT ARE NOT INCLUDED IN SLIDING FEE, THE COST \$45.00

COVID & FLU VACCINE IS NOT INCLUDED IN SLIDING FEE, THE COST IS \$155.00

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931-879-5864 (Clinic)
931-879-0796 (Fax)
www.jamestownmedical.com

Clinic Address:
101 S Duncan St Suite C
Jamestown, TN 38556



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GOOD FAITH ESTIMATE

You have the right to receive a “Good Faith Estimate” explaining how much your health care will cost. Under the law, health care providers must notify patients, **who are uninsured or have health care coverage but wish to self pay and not use the coverage**, of the availability of an estimate of their bill for health care items and services before those items or services are provided.

- If you meet the above criteria, you have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services.
- If you schedule a health care item or service at least 3 business days in advance and you wish to have a Good Faith Estimate, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least \$400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill by calling the Billing Department at (931) 879-5864
- Make sure to save a copy or picture of your Good Faith Estimate and the bill. For questions or more information about your right to a Good Faith Estimate
- Visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059