BEST LLC
Healthcare Discount Fee Policy

Discount Application Process/Policy

A completed application including required documentation of the household income, and family size, must be on file and approved by the billing office before a discount will be granted.
Adolescent patients seeking confidential care are exempt from the application process, and services are provided at the nominal rate.

BEST LLC offers a Sliding Fee Discount Program to all who are unable to pay for their services. BEST LLC Services will not base program eligibility on a person's ability to pay; whether payment for services are made under Medicare, Medicaid, or CHIP; and the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. The Federal Poverty Guidelines are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

Services Covered and Excluded

BEST LLC Discounted/Sliding Fee Application

It is the policy of BEST LLC, to provide services regardless of the patient's ability to pay. Discounts are offered based upon family income and household size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

Services Covered and Excluded

The discount will apply to all services received at this facility, but not those services which are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist or other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. Approved applicants will need to complete a SFS application and re-apply for the sliding fee discount every 6 months. Please inquire at the front desk if you have questions.
Number of related persons living in your household: _____

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependent Children under age 18			
Total			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment, and public aid.

I certify that the family household size and income information shown above is correct.

Name (Print) _____

Signature_____

Date:

Date _____

Office Use Only

Patient Name _____ Discount _____

Date of Service_____ Approved by _____

BEST LLC
FAMILY ASSISTANCE PLAN APPLICATION

NAME OF HEAD OF HOUSEHOLD	
SOCIAL SECURITY NUMBER (OPTIONAL)	

PLEASE LIST SPOUSE AND DEPENDENTS UNDER AGE 18

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	OTHER	TOTAL
GROSS WAGES, SALARIES, TIPS, ETC.				
SOCIAL SECURITY, PENSION, ANNUITY, AND VETERAN'S BENIFITS				
OTHER:				

Source	Self	Spouse	Other	Total
Alimony, child support, military family allotments				
Income from business self-employment, and dependents				
Rent, interest, dividend, and other income				
TOTAL INCOME				

I certify that the family size and household income information shown above is correct.

Name (print) _____ Date _____

Signature _____

Verification Checklist (attach copies)	YES X	NO X
Identification/Address: Driver's license, utility bill, employment ID (optional)		
Income: Prior year tax return, three most recent pay stubs, or other		