HELP-US HELP-U, INC. *d/b/a UNIFY Health & Wellness*

FORM 6 YOUR RIGHTS, COMPLAINTS, AND PAYING FOR CARE

Universal. Read this, keep a copy, and sign at the bottom. One page of reading, plus the fee table.

Patient name	Date of birth

Client ID	Date	Staff

YOUR RIGHTS

Everyone receives services here regardless of race, ethnic origin, economic status, sexual orientation, gender identity, immigration status, housing status, substance use, or religion. A patient has the right to be treated with dignity, to safe care, to take part in their care plan, to refuse any treatment, to confidentiality, to see and copy their records, to know what things cost, to language help at no cost, to complain, and to ask for a different member of staff.

HUHU asks that patients give accurate information, tell staff when something changes, let staff know if they cannot make an appointment, and treat staff and other patients with respect.

IF SOMETHING GOES WRONG

Tell any member of staff. A patient does not have to complain to the person they have a problem with, and may complain anonymously. Complaining will never affect care.

1. Tell any staff member, verbally or in writing; it is acknowledged within two business days. 2. The Program Director looks into it and gives an answer within ten business days. 3. If unsatisfied, the patient may ask the Chief Executive Officer to review it, with a response within thirty days. 4. A patient may also complain to the Florida Department of Health at 1-888-419-3456, or to the federal Office for Civil Rights at 1-800-368-1019. Grievances about services funded by a specific program may also be raised with that funder or the county health department.

PAYING FOR CARE

Nobody is refused care because they cannot pay. A discount based on income and family size is available and HUHU will help the patient apply. There is no charge for a missed appointment. Copy charges for records are as permitted by law and are waived if the charge would prevent a patient from getting their record.

A patient is responsible for amounts insurance does not cover, less any discount they qualify for. Patients should report insurance changes before their next visit, since otherwise they may be billed for something that would have been covered. Patients should report income or family size changes, since that may change their discount. Services from outside providers and laboratories may be billed separately by them.

APPLYING FOR THE DISCOUNT — TICK ONE

☐ I want to apply for the discount ☐ I am giving my income details but declining the discount
☐ I am declining to give income details and accept the full charge

Any of the following helps but none is required: pay stub, W-2, 1040 or 1099, benefit or award letter, disability or retirement statement, unemployment or food assistance letter, child support or alimony record, veterans letter, or Social Security earnings statement. If a patient has none of these, their own signed statement of income is enough.

2026 SLIDING FEE SCALE (HHS FEDERAL POVERTY GUIDELINES, EFFECTIVE JANUARY 13, 2026)

Household size	100% FPL	125% FPL	150% FPL	175% FPL	200% FPL
1	$15,960	$19,950	$23,940	$27,930	$31,920
2	$21,640	$27,050	$32,460	$37,870	$43,280
3	$27,320	$34,150	$40,980	$47,810	$54,640
4	$33,000	$41,250	$49,500	$57,750	$66,000
5	$38,680	$48,350	$58,020	$67,690	$77,360
6	$44,360	$55,450	$66,540	$77,630	$88,720

For each household member beyond six, add $5,680 per year to every column, or contact ASPE at aspe.hhs.gov for the full table through household size eight.

Category	Income band	Discount
A	At or below 100% FPL	Nominal fee only
B	101% to 125% FPL	90% discount
C	126% to 150% FPL	75% discount
D	151% to 175% FPL	50% discount
E	176% to 200% FPL	25% discount
F	Above 200% FPL	Full fee

Patient signature	Date	
Printed name	**Guardian, if any**	**Staff**