Sliding Fee Program

As a Federally Qualified Healthcare Clinic, North Olympic Healthcare Network is able to offer most services on a sliding fee schedule. This means that depending on your household income and family size, you may be eligible for fee discounts.

Sliding Fee Program Eligibility:

North Olympic Healthcare Network staff is available to assist patients with determining if they are eligible for discounts via the Sliding Fee Program. Patients who meet the necessary application requirements may receive the discounts. We use the Federal Poverty Guidelines to determine the nominal fee available. You will find a schedule and application attached.

How to apply for the Sliding Fee Program:

Please complete the attached application and return it to our Accounts Representative. Once you have supplied the completed application and all the necessary information your, application will be reviewed for eligibility and you will be contacted with a determination.

If you have questions about the Sliding Fee Program at North Olympic Healthcare Network, please call our business office at (360)452-8086 ext 2826.

Note:

YOU CAN APPLY FOR MEDICAL BENEFITS THROUGH THE WASHINGTON HEALTHCARE BENEFITS EXCHANGE ONLINE AT http://www.wahbexchange.org/ **OR BY CONTACTING A OUR NAVIGATOR AT 360-452-7891 X 2846.**

Sliding Fee Program Application

Today's Date: ______/______/________ Account #: _______________________

Applicant Name: _______________________________ Date of Birth: ____/____/_____

Address: ____

City: ___________________________ State: __________ Zip Code: _______________

Telephone Number: (______) ______-________ [_] Home [_] Cell [_] Message phone

Family Members:

Please list all household members residing at the above address and
Date of birth respectively.

1. ____ DOB: ______/______/________

2. ____ DOB: ______/______/________

3. ____ DOB: ______/______/________

4. ____ DOB: ______/______/________

5. ____ DOB: ______/______/________

6. ____ DOB: ______/______/________

7. ____ DOB: ______/______/________

8. ____ DOB: ______/______/________

9. ____ DOB: ______/______/________

10. ____ DOB: ______/______/________

Please provide ***any*** of the following documents to assist in the determination of eligibility. Please indicate the reason if unable to provide.

1. Proof of income for **each** household member:

    a. Pay stubs for the 3 month period prior to application.

    Unable to provide because: ____

    b. Letters approving/denying unemployment compensation.

    Unable to provide because: ____

    c. Proof of Social Security Benefits and/or Pension payments, if applicable.
    Unable to provide because: ____

    d. Checking and Savings Statements for 3 months prior to application.

    Unable to provide because: ____

    e. Do you own rental property and receive income from it? Yes _____No _____

    If Yes, monthly income from rentals __________________________

    f. Do you have any other sources of income? Yes _____ No _____

    If yes, please explain ____

    ____

2. Certain expenses may be considered as a deduction to your income. Do you pay any of the following?

    a. Do you pay monthly alimony? Yes _____ No _____

    If yes, amount $ _________________________

    b. Have monthly student loans? Yes _____ No _____

    If yes, amount $ _________________________

    c. Pay monthly child support Yes _____ No _____

    If yes, amount $ _________________________

    ** If so please attach appropriate documents to support.

I, THE APPLICANT FOR THE SLIDING FEE PROGRAM, AFFIRM THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND AGREE TO PROVIDE ANY ADDITIONAL INFORMATION AS REQUESTED IN ORDER TO DETERMINE ELIGIBILITY.

Signature: ___________________________________ Date: ______/______/_______

Relationship if other than patient: ____

IF YOU HAVE ANY QUESTIONS CONCERNING THIS APPLICATION, PLEASE DIRECT YOUR QUESTIONS TO THE PATIENT ACCOUNTS REPRESENTATIVE AT 360-452-8086.

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Do not write below this line - For office personnel use only.

This document was received on: ___________________________

Information verified by: ___________________________

Percent of Federal Poverty Guideline: _______________________

Eligible for balance reduction: Yes _____ No ______

Amount due from patient: $____________________

Signature: _______________________________________ Date: ____________

Title: _______________________________________

CFO Signature: ____________________________________ Date: ____________

Patient Notified: ____________________Statement Sent: ____________________

2016 North Olympic Healthcare Network Sliding Fee Scale

Family Size	Category slide >>	A	B	C	D	E	N/A
	POVERTY LEVEL	0-**100%**	101-**125%**	126-**150%**	151-**175%**	176-**200%**	**>200**
	Patient responsibility =	Full discount $0 balance	10% of balance	20% of balance	30% of balance	40% of balance	100% of balance
1	Annual (up to)	$11,880.00	$14,850.00	$17,820.00	$20,790.00	$23,760.00	$23,761.00
	Monthly	$990.00	$1,237.50	$1,485.00	$1,732.50	$1,980.00	$1,981.00
	Weekly	$228.00	$285.00	$342.00	$399.00	$456.00	$457.00
2	Annual (up to)	$16,020.00	$20,025.00	$24,030.00	$28,035.00	$32,040.00	$32,041.00
	Monthly	$1,335.00	$1,668.75	$2,002.50	$2,336.25	$2,670.00	$2,671.00
	Weekly	$308.00	$385.00	$462.00	$539.00	$616.00	$617.00
3	Annual (up to)	$20,160.00	$25,200.00	$30,240.00	$35,280.00	$40,320.00	$40,321.00
	Monthly	$1,680.00	$2,100.00	$2,520.00	$2,940.00	$3,360.00	$3,361.00
	Weekly	$387.00	$483.75	$580.50	$677.25	$774.00	$775.00
4	Annual (up to)	$24,300.00	$30,375.00	$36,450.00	$42,525.00	$48,600.00	$48,601.00
	Monthly	$2,025.00	$2,531.25	$3,037.50	$3,543.75	$4,050.00	$4,051.00
	Weekly	$467.00	$583.75	$700.50	$817.25	$934.00	$935.00
5	Annual (up to)	$28,440.00	$35,550.00	$42,660.00	$49,770.00	$56,880.00	$56,881.00
	Monthly	$2,370.00	$2,962.50	$3,555.00	$4,147.50	$4,740.00	$4,741.00
	Weekly	$546.00	$682.50	$819.00	$955.50	$1,092.00	$1,093.00
6	Annual (up to)	$32,580.00	$40,725.00	$48,870.00	$57,015.00	$65,160.00	$65,161.00
	Monthly	$2,715.00	$3,393.75	$4,072.50	$4,751.25	$5,430.00	$5,431.00
	Weekly	$626.00	$782.50	$939.00	$1,095.50	$1,252.00	$1,253.00
7	Annual (up to)	$36,730.00	$45,912.50	$55,095.00	$64,277.50	$73,460.00	$73,461.00
	Monthly	$3,060.00	$3,825.00	$4,590.00	$5,355.00	$6,120.00	$6,121.00
	Weekly	$706.00	$882.50	$1,059.00	$1,235.50	$1,412.00	$1,413.00
8	Annual (up to)	$40,890.00	$51,112.50	$61,335.00	$71,557.50	$81,780.00	$81,781.00
	Monthly	$3,407.00	$4,258.75	$5,110.50	$5,962.25	$6,814.00	$6,815.00
	Weekly	$786.00	$982.50	$1,179.00	$1,375.50	$1,572.00	$1,573.00
Each Additional Person	Annual (up to)	$4,160.00	$5,200.00	$6,240.00	$7,280.00	$8,320.00	$8,321.00
	Monthly	$346.00	$432.50	$519.00	$605.50	$692.00	$693.00
	Weekly	$80.00	$100.00	$120.00	$140.00	$160.00	$161.00