

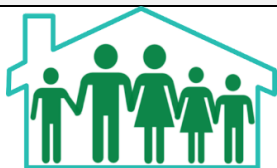


SLIDING FEE DISCOUNT PROGRAM INFORMATION

WHY SHOULD I SIGN UP FOR THE PROGRAM?

Neighborhood Health Center (NHC) offers discounted services to patients living at or below 200% of the most current Federal Poverty Guidelines (FPG). Eligibility to participate in the program is based only on the patient's household income and family size, as it relates to FPGs. All patients are encouraged to apply, including patients with insurance. Discounts apply to all NHC services provided directly at NHC clinics and those offered in referral. Discounts vary depending on the patient's assigned discount pay class (see Discount Classes A-D in the Monthly Income table below) and the service being used by the patient at the time of appointment (i.e. medical, dental, or behavioral health). Please take a moment to review this information sheet prior to filling out your application. If you have questions, please ask an NHC staff member for assistance.

WHO SHOULD I INCLUDE IN MY FAMILY SIZE?



NHC defines a family as a group of two or more people living together who are financially supporting one another.

Do **NOT** include:

- Family members who do not live with you
- Family members who are financially independent

Still not sure who to include? Ask us!

WHAT IS ACCEPTABLE PROOF OF INCOME?

For each member contributing income to the family, attach at least one of the following documents to your application:

- ✓ Two (2) weeks of most recent pay stubs
- ✓ Check stubs from Unemployment Insurance
- ✓ Previous year W-2
- ✓ Previous year completed tax return
- ✓ Government-issued documentation for other non-wage income such as Social Security, Worker's Comp, Cash Assistance, Child Support, Alimony, Veteran's Benefits, Retirement, or Pension
- ✓ Previous three (3) months of bank statements
- ✓ Letter from employer
- ✓ If self-employed: prior year tax return or most recent three (3) months of bank statements

WHAT DISCOUNT WILL I RECEIVE?

Below is a table displaying the 2022 Federal Poverty Guidelines (FPG). Only patients reporting a family income at or below 200% of FPG will qualify. Columns A through D are eligible for discounted services. Column E (above 200% FPG) must pay in full for charges and will not receive a discount. If you fall within Column E, you are not eligible to participate in the program.

MONTHLY INCOME											
Discount Class		A		B		C		D		E	
FPG		0-100%		>100-133%		>133-166%		>166-200%		>200%	
Family Size	1	\$0	\$1,133	\$1,134	\$1,506	\$1,507	\$1,880	\$1,881	\$2,265	\$2,266	& Up
	2	\$0	\$1,526	\$1,527	\$2,029	\$2,030	\$2,533	\$2,534	\$3,052	\$3,053	& Up
	3	\$0	\$1,919	\$1,920	\$2,552	\$2,553	\$3,186	\$3,187	\$3,838	\$3,839	& Up
	4	\$0	\$2,313	\$2,314	\$3,076	\$3,077	\$3,839	\$3,840	\$4,625	\$4,626	& Up
	5	\$0	\$2,706	\$2,707	\$3,599	\$3,600	\$4,492	\$4,493	\$5,412	\$5,413	& Up
	6	\$0	\$3,099	\$3,100	\$4,122	\$4,123	\$5,145	\$5,146	\$6,198	\$6,199	& Up
	7	\$0	\$3,493	\$3,494	\$4,645	\$4,646	\$5,798	\$5,799	\$6,985	\$6,986	& Up
	8	\$0	\$3,886	\$3,887	\$5,168	\$5,169	\$6,450	\$6,451	\$7,772	\$7,773	& Up
	9	\$0	\$4,279	\$4,280	\$5,691	\$5,692	\$7,103	\$7,104	\$8,558	\$8,559	& Up
	10	\$0	\$4,673	\$4,674	\$6,214	\$6,215	\$7,756	\$7,757	\$9,345	\$9,346	& Up

FPG: Federal Poverty Guidelines, published by HHS, effective 1/12/2022
For families/households with more than 10 persons, add \$393 for each additional person

EXAMPLE 1

Susan is a single mother of two young children, Susan also cares for her mother, who lives with her and her children. Susan's family size is 4. Susan is the only person in her family earning income. Susan earns \$2,600 per month in income. Susan belongs to Discount Class B.

EXAMPLE 2

Jose is married to his wife Miranda. They have three young children who live with them. Jose earns \$2,300 per month at his job. Jose's wife earns \$2,700 per month. Together, the couple earns \$5,000 per month. Jose's family size is 5. Jose belongs to Discount Class D.

WHAT AM I RESPONSIBLE TO PAY?

Once you figure out what Discount Class you belong to (A-D), discounts vary depending on the service you are using at the time of your service. Services are broken into groups and include medical, dental, and behavioral health.

Discounts apply to clinical services. Note that dental and pharmacy supplies and equipment have separate discounts because they are not clinical services.

	A	B	C	D	E
Medical & Clinical Pharmacy Services	\$25	\$35	\$40	\$45	100% of Full Charges
Dental Services*	\$25	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Dental Supplies & Equipment*	50% of Full Charges	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Behavioral Health & Psychiatry Services	\$5	\$10	\$15	\$20	100% of Full Charges
Pharmacy Dispensed Prescription Fees**	\$5 Dispensing Fee + Discounted Medication Cost	\$8 Dispensing Fee + Discounted Medication Cost	\$10 Dispensing Fee + Discounted Medication Cost	\$12 Dispensing Fee + Discounted Medication Cost	100% of Full Charges

*\$25 payment expected at the time of service.

**Ask your Pharmacist for a quote on your medications. Call 503-941-3160 for more information.

EXAMPLE 1

I belong to Discount Class B. I came in today for a medical visit with my Doctor. I am responsible to pay \$35 for my visit. The remainder of my charges will be adjusted by NHC so that \$35 is my only responsibility.

EXAMPLE 2

I belong to Discount Class C. I came in today for a dental exam and cleaning. The total of these charges was \$300. I am responsible to pay 60% of these charges. The remainder of my charges will be adjusted by NHC so that \$180 is my only responsibility (\$180 = 60% of \$300 charges).

EXAMPLE 3

I belong to Discount Class A. I came in today for an appointment to discuss my diabetes with a behaviorist. I am responsible to pay \$5 for my visit. The remainder of my charges will be adjusted by NHC so that \$5 is my only responsibility.

EXAMPLE 4

I belong to Discount Class D. I am diabetic and NHC is going to deliver my insulin medication to my home. My pharmacist told me I will pay a total of \$16 for my insulin. This includes the cost for the medication plus the dispensing fee.



I NEED MORE INFORMATION

Not sure who to include in your family size? Not sure what to bring to prove your income? Not sure what discount class you will qualify for? Not sure what you will be charged for a specific service?

Ask the front desk staff at your NHC clinic to answer any additional questions you have.



SLIDING FEE DISCOUNT PROGRAM

APPLICATION

INSTRUCTIONS

1. In order to receive discounted services, all patients must apply annually for the Sliding Fee Discount Program. Eligibility is based on family size and household income, as it relates to current Federal Poverty Guidelines.
2. Please read the *Sliding Fee Discount Program Information* sheet. If you have additional questions, please ask the front desk.
3. Please fill out the application and return it to Neighborhood Health Center (NHC) with proof of income attached. Don't forget to sign and date your application.
4. If you can't attach proof of income to your application today, please return proof of income to NHC within 30 days of submitting this application.
5. List yourself as the first family member, followed by others. For individuals not earning an income (for example, a child within your family), enter zero (\$0) for their monthly income.

PERSONAL INFORMATION

Full Name	
Address	
Phone Number	
Today's Date	

FAMILY MEMBERS

- Family is defined as a group of two or more people living together who are financially supporting one another.
- Report \$0 under 'Monthly Income' for any family members who do not support you financially.

Full Name	Date of Birth	Relationship	Monthly Income (before taxes)
		Self	\$
			\$
			\$
			\$
			\$
			\$
			\$

IF YOU REPORT ZERO FAMILY INCOME OR A SOURCE OF INCOME THAT CANNOT BE PROVED

How long have you been without a taxable source of income?	<input type="checkbox"/> > 6 months <input type="checkbox"/> 6 months-1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> Over 2 years
Why are you unable to provide proof of income?	

ATTESTATIONS

Please read and initial next to each attestation

	I attest that I have read the <i>Sliding Fee Discount Program Information</i> sheet and understand requirements to participate in the program.
	I understand that discount will not be applied until my application <u>and</u> proof of income are reviewed and accepted by NHC. I understand that if I cannot provide proof of income, discount will not be applied until my request to waive proof of income is reviewed and approved by NHC's Chief Operating Officer or their designee.
	I understand that eligibility in the program is valid one year from the date my application is approved. I understand I must reapply each year to remain in the program.
	I understand that should my income or family size change during my one-year period of eligibility, I will report changes to NHC and reapply for the program.
	I understand that should my insurance prohibit a waiver of my co-pay, the full co-pay will be collected at the time of service. If you are unsure, contact your insurance company.

SIGNATURE

I certify that the information stated is true and accurate by signing this form. If false information is used to obtain assistance, I will be removed from the sliding fee discount program.

Applicant Signature	Date



-----DO NOT WRITE BELOW THIS LINE-----

OFFICE USE ONLY

Applicant/s Information	
Patient/s MRN	
Monthly Family Income (from table on pg.1)	\$
Family Size (from table on pg.1)	
Proof of Income Status at Time of Application	<input type="checkbox"/> A. Yes, proof attached <input type="checkbox"/> B. Pending, 30-day grace period <input type="checkbox"/> C. No, applicant has listed zero or cash source of income, pending approval by COO or designee
Date	
Reviewed By	

Proof of Income Status: A or B	
Monthly Family Income (verified by proof)	\$
Discount Class	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
Date Verified	
Reviewed By	
Proof of Income Status: C	
Decision	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Discount Class	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
Date of Review	
Signature of COO or Designee	