North Olympic Healthcare NETWORK

Sliding Fee Program

As a Federally Qualified Healthcare Clinic, North Olympic Healthcare Network can 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 in determining their eligibility for discounts through the Sliding Fee Program. North Olympic Healthcare Network uses the current Federal Poverty Guidelines to determine the discount 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 the North Olympic Healthcare Network Accounts Representative. Eligibility will be based on subsequent review of the application and additional relevant materials. 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. 2858.

Note:
YOU CAN APPLY FOR MEDICAL BENEFITS THROUGH THE WASHINGTON HEALTHCARE BENEFITS EXCHANGE ONLINE AT http://www.wahbexchange.org/ **OR BY CONTACTING OUR PATIENT NAVIGATOR AT 360-452-7891 X 2855.**

Approved by BJB on 1 / 29 /2019

North Olympic Healthcare NETWORK

IF YOU HAVE ANY QUESTIONS CONCERNING THIS APPLICATION, PLEASE DIRECT YOUR QUESTIONS TO THE PATIENT ACCOUNTS REPRESENTATIVE AT **360-452-8086 ext. 2858**.

Sliding Fee Program Application

Today's Date: _____/_____/_____ Guarantor #: _____
Guarantor Name: _____ Date of Birth: ___/___/___
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: (_____) _____-_____ [ ] Home [ ] Cell [ ] Message phone

Employment Status:
[ ]Employed (Date of Hire_____) **[ ]**Unemployed (How long? _____)
[ ]Self-employed **[ ]**Student **[ ]**Disabled **[ ]**Retired **[ ]** Other (_____)

Household Information:

Total Family Members _____	Include everyone related to you by birth, marriage or adoption that live together.				
Name	Date of Birth	Relationship to Guarantor	Receiving Income?	Source of Income (if any)	Total GROSS Monthly Income
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		

****All adult family members' income must be disclosed. Sources of income include, but are not limited to**:

- Wages
- Unemployment
- Self-Employment
- Worker's Compensation
- Rental Income
- Disability
- Social Security
- Child Support
- Spousal Support
- Work Study
- Pension
- Retirement Account Distributions

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Received date_____ Account # _____

Please provide ***all*** of the following documents to assist in the determination of eligibility. **Please indicate attached, not applicable or reason unable to provide.**

Proof of income for each household member:

- Pay stubs for the 3 month period prior to application.
  [ ] Attached [ ] not applicable
  [ ]*Unable to provide because*: _____
- Letters approving/denying unemployment compensation.
  [ ] Attached [ ] not applicable
  [ ]*Unable to provide because*: _____
- Documents showing acceptance /denying eligibility for Medicaid and/or medical coverage through the Washington Health Benefit Exchange system.
  [ ] Attached [ ] not applicable
  [ ]*Unable to provide because*: _____
- Proof of Social Security Benefits and/or Pension payments, if applicable.
  [ ] Attached [ ] not applicable
  [ ]*Unable to provide because:* _____
- *All* Checking *and* Savings Statements for 3 months prior to application.
  [ ] Attached [ ] not applicable
  [ ]*Unable to provide because*: _____
- Other sources of income: _____(Source)
  [ ] Attached [ ] not applicable
  [ ]*Unable to provide because*: _____

Certain expenses / deductions can be considered. Do you pay any of the following? If yes, please indicate amount per month and attach supporting documentation.

- Do you pay monthly alimony? _____/mo.
- Have monthly student loans? _____/mo.
- Pay monthly child support? _____/mo.

****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. I AGREE TO PROVIDE ANY ADDITIONAL INFORMATION AS REQUESTED IN ORDER TO DETERMINE ELIGIBILITY.

Signature: _____ Date: _____/_____/_____

Form Approved by: BJB 12 / 2 / 2019 _____

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Received date_____ Account # _____