Sliding Fee Program Instructions

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 determination.

Household Size: All people related by blood, marriage, and/or adoption should be included on the application.

Dependents: Children under the age of 19 or (24 if a full-time student), that are related by blood, legal adoption, and/or legally disabled adults may be considered dependents.

Income: ALL income must be disclosed. Not all income is considered in determining Federal Poverty status, but all must be declared and proven with documentation.

Examples Include:

- Annual Social Security statement
- Pay stubs for 3 months of income, *OR* most recent pay stub *AND* hire date
- Unemployment award letter
- Attestation of *how expenses are being met* if no documentation can be provided
- Self-employment – most recent tax return and/or 3 month's income and expense reports

Bank Statements: 3 most recent months of all checking and savings accounts. Please provide explanations for ALL deposits not counted as income.

Examples Include:

- Repayment of a loan to a friend
- Family member uses bank account as well
- Family providing assistance to applicant
- Refund from a prior purchase

Submission:

- Deliver your completed, signed application with ALL required documents to any NOHN representative.
- Mail to:

NOHN PATIENT ACCOUNTS

240 W FRONT ST, STE A

PORT ANGELES, WA 98362

Fax To: (360) 452-8087
Email to: patientaccounts@nohn-pa.org

If you have any questions regarding the required documentation, please contact our Financial Coordinator at 360-452-8086.

**We cannot guarantee security of personal information sent via email

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

North Olympic Healthcare NETWORK

Sliding Fee Program Application

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

PATIENT AND APPLICANT INFORMATION

Applicant Name: _____ Birth Date: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Number: _____ Email: _____

EMPLOYMENT STATUS OF PERSON RESPONSIBLE FOR PAYING BILL

☐ Employed (date of hire: _____) ☐ Unemployed (how long: _____)

☐ Self-Employed ☐ Student ☐ Disabled ☐ Retired ☐ Other (_____)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption. Attach additional page if needed.

NAME	DOB	RELATIONSHIP TO PATIENT	RECEIVING INCOME?	SOURCE OF INCOME
		Self	Y / N	
			Y / N	
			Y / N	
			Y / N	
			Y / N	
			Y / N	
			Y / N	

INCOME INFORMATION

You must provide proof of income with your application. Income verification is required to determine eligibility. All family members 18 years or older must disclose their income. Please provide proof of ALL sources of income.

Please provide **ALL** that are applicable:

- □ Current Pay Stubs (3 months)
- □ Social Security / Pension / Retirement Statement
- □ Most Current Tax Return
- □ Unemployment Compensation Letter
- □ Family / Medical Leave Documents
- □ Investment Statements
- □ Certified Court Orders / Child Support / Spousal Maintenance
- □ Checking and Savings Statements for Last 3 Months
- □ Proof of Eligibility for Medicaid / TANF
- □ Other: _____

If you have no proof of income or no income, please use provided attestation letter for explanation

PATIENT AGREEMENT

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

Applicant Signature: _____ **Date:** _____

- **Intentionally not providing complete documentation will be considered the same as fraudulently attesting to your income.**
- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we will check all the information and may ask for additional information or proof of income.
- Applicants are responsible for notifying NOHN of any changes to income.

****

Do Not Write Below This Line - Administrative Use Only

North Olympic Healthcare NETWORK

North Olympic Healthcare Network
240 West Front Street | Suite A
Port Angeles, WA 98362-2609
(360) 452-7891 P | (360) 452-8087 F

SLIDING FEE PROGRAM SERVICES

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

Application/Eligibility for Sliding Fee Program (SFP):

Patients must apply and qualify to receive discounts on services, schedules are available with application. Staff are available to assist patients in determining their eligibility. Eligibility will be based on review of the application and additional relevant materials. Complete the application in full and return it to NOHN Patient Accounts Department. You will be contacted with determination. In addition to our sliding fee program, we also offer payment plans – with or without the discount from our sliding fee program. Please contact our Patient Accounts department at (360) 452-7891, option 7 for any assistance with your application or payment plan.

Lab Costs: Some services may incur lab costs for the production of materials. Lab costs are due prior to performing services. *Sliding fee discounts do not apply to lab costs.*

Upper-Level Services

In addition to preventive and restorative dentistry, we offer services such as root canals, crowns, and bridges. There are fees associated with these upper-level services:

Lab Costs: Some upper-level services may incur lab costs for the production of materials. Lab costs are due prior to performing services. *Sliding fee discounts do not apply to lab costs.*

Service Fee: A nominal fee will apply for all upper-level services and be due at the time of scheduling.

Walgreens Pharmacy

If patients qualify for the sliding fee discount program and choose to utilize Walgreens Pharmacy Prescription Services, a card will be included with their approval letter. Patients must inform their healthcare provider they would like to use this service, to have all prescriptions switched to qualifying Walgreens pharmacy.

Olympic Medical Center

If the patient chooses to go to Olympic Medical Center or one of its Specialty Clinics, the provider will generate an appropriate referral at an appointment. The patient's SFP Tier will be noted on the chart. Olympic Medical Center has a separate financial assistance program and application process. *

For more information, please visit nohn-pa.org/sliding_fee_program.php or scan the QR code below with your smartphone. **Note: These resources may have different guidelines for sliding scale and patients may be referred to their financial department for further instruction.*

2024 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 =	100% Discount	90% Discount	80% Discount	70% Discount	60% Discount	No Discount
1	Annual (up to)	$15,060.00	$18,825.00	$22,590.00	$26,355.00	$30,120.00	$30,121.00
	Monthly	$1,255.00	$1,568.75	$1,882.50	$2,196.25	$2,510.00	$2,510.08
	Weekly	$289.62	$362.02	$434.42	$506.83	$579.23	$579.25
2	Annual (up to)	$20,440.00	$25,550.00	$30,660.00	$35,770.00	$40,880.00	$40,881.00
	Monthly	$1,703.33	$2,129.17	$2,555.00	$2,980.83	$3,406.67	$3,406.75
	Weekly	$393.08	$491.35	$589.62	$687.88	$786.15	$786.17
3	Annual (up to)	$25,820.00	$32,275.00	$38,730.00	$45,185.00	$51,640.00	$51,641.00
	Monthly	$2,151.67	$2,689.58	$3,227.50	$3,765.42	$4,303.33	$4,303.42
	Weekly	$496.54	$620.67	$744.81	$868.94	$993.08	$993.10
4	Annual (up to)	$31,200.00	$39,000.00	$46,800.00	$54,600.00	$62,400.00	$62,401.00
	Monthly	$2,600.00	$3,250.00	$3,900.00	$4,550.00	$5,200.00	$5,200.08
	Weekly	$600.00	$750.00	$900.00	$1,050.00	$1,200.00	$1,200.02
5	Annual (up to)	$36,580.00	$45,725.00	$54,870.00	$64,015.00	$73,160.00	$73,161.00
	Monthly	$3,048.33	$3,810.42	$4,572.50	$5,334.58	$6,096.67	$6,096.75
	Weekly	$703.46	$879.33	$1,055.19	$1,231.06	$1,406.92	$1,406.94
6	Annual (up to)	$41,960.00	$52,450.00	$62,940.00	$73,430.00	$83,920.00	$83,921.00
	Monthly	$3,496.67	$4,370.83	$5,245.00	$6,119.17	$6,993.33	$6,993.42
	Weekly	$806.92	$1,008.65	$1,210.38	$1,412.12	$1,613.85	$1,613.87
7	Annual (up to)	$47,340.00	$59,175.00	$71,010.00	$82,845.00	$94,680.00	$94,681.00
	Monthly	$3,945.00	$4,931.25	$5,917.50	$6,903.75	$7,890.00	$7,890.08
	Weekly	$910.38	$1,137.98	$1,365.58	$1,593.17	$1,820.77	$1,820.79
8	Annual (up to)	$52,720.00	$65,900.00	$79,080.00	$92,260.00	$105,440.00	$105,441.00
	Monthly	$4,393.33	$5,491.67	$6,590.00	$7,688.33	$8,786.67	$8,786.75
	Weekly	$1,013.85	$1,267.31	$1,520.77	$1,774.23	$2,027.69	$2,027.71
Each Additional Person	Annual (up to)	$5,380.00	$6,725.00	$8,070.00	$9,415.00	$10,760.00	$10,761.00
	Monthly	$448.33	$560.42	$672.50	$784.58	$896.67	$896.75
	Weekly	$103.46	$129.33	$155.19	$181.06	$206.92	$206.94

2024 NOHN Upper Level Dental Services Sliding Fee Scale

Lab fees are collected prior to service start date and not included with scale calculations below. The nominal fee is due on date of service with remaining balance billed to patient after service date.

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 =	Nominal Fee $150.00	Nominal Fee $150.00 + 10%	Nominal Fee $150.00 + 20%	Nominal Fee $150.00 + 30%	Nominal Fee $150.00 + 40%	No Discount
1	Annual (up to)	$15,060.00	$18,825.00	$22,590.00	$26,355.00	$30,120.00	$30,121.00
	Monthly	$1,255.00	$1,568.75	$1,882.50	$2,196.25	$2,510.00	$2,510.08
	Weekly	$289.62	$362.02	$434.42	$506.83	$579.23	$579.25
2	Annual (up to)	$20,440.00	$25,550.00	$30,660.00	$35,770.00	$40,880.00	$40,881.00
	Monthly	$1,703.33	$2,129.17	$2,555.00	$2,980.83	$3,406.67	$3,406.75
	Weekly	$393.08	$491.35	$589.62	$687.88	$786.15	$786.17
3	Annual (up to)	$25,820.00	$32,275.00	$38,730.00	$45,185.00	$51,640.00	$51,641.00
	Monthly	$2,151.67	$2,689.58	$3,227.50	$3,765.42	$4,303.33	$4,303.42
	Weekly	$496.54	$620.67	$744.81	$868.94	$993.08	$993.10
4	Annual (up to)	$31,200.00	$39,000.00	$46,800.00	$54,600.00	$62,400.00	$62,401.00
	Monthly	$2,600.00	$3,250.00	$3,900.00	$4,550.00	$5,200.00	$5,200.08
	Weekly	$600.00	$750.00	$900.00	$1,050.00	$1,200.00	$1,200.02
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	Monthly	$3,048.33	$3,810.42	$4,572.50	$5,334.58	$6,096.67	$6,096.75
	Weekly	$703.46	$879.33	$1,055.19	$1,231.06	$1,406.92	$1,406.94
6	Annual (up to)	$41,960.00	$52,450.00	$62,940.00	$73,430.00	$83,920.00	$83,921.00
	Monthly	$3,496.67	$4,370.83	$5,245.00	$6,119.17	$6,993.33	$6,993.42
	Weekly	$806.92	$1,008.65	$1,210.38	$1,412.12	$1,613.85	$1,613.87
7	Annual (up to)	$47,340.00	$59,175.00	$71,010.00	$82,845.00	$94,680.00	$94,681.00
	Monthly	$3,945.00	$4,931.25	$5,917.50	$6,903.75	$7,890.00	$7,890.08
	Weekly	$910.38	$1,137.98	$1,365.58	$1,593.17	$1,820.77	$1,820.79
8	Annual (up to)	$52,720.00	$65,900.00	$79,080.00	$92,260.00	$105,440.00	$105,441.00
	Monthly	$4,393.33	$5,491.67	$6,590.00	$7,688.33	$8,786.67	$8,786.75
	Weekly	$1,013.85	$1,267.31	$1,520.77	$1,774.23	$2,027.69	$2,027.71
Each Additional Person	Annual (up to)	$5,380.00	$6,725.00	$8,070.00	$9,415.00	$10,760.00	$10,761.00
	Monthly	$448.33	$560.42	$672.50	$784.58	$896.67	$896.75
	Weekly	$103.46	$129.33	$155.19	$181.06	$206.92	$206.94

North Olympic Healthcare NETWORK

Sliding Fee Discount Program Attestation Letter

Patient name _____Date_____

Please explain why you are unable to provide proof of income for the Sliding Fee program application:

_____

_____

_____

_____

_____

_____

_____

_____

Please provide contact information of a person who is not applying with whom we can verify the above statement:

Name _____ Relationship_____

Address_____ Phone# _____

City ST ZIP _____

_____

Applicant Signature *Date*