

Sliding Fee Program Application

Instructions:

Please complete each section of the following application in full. For assistance with your application, please contact our Fiscal Program Coordinator at (360) 452-8086, option 2. You may deliver your completed, **signed application** with ALL required documents to our Fiscal Program Coordinator via:

- In person:
NOHN Administrative Services Center
923 E. 1st Street
Port Angeles, WA 98362
- MyChart
- Fax: (360) 452-8087 – Attn: Sliding Fee
- Mail:
NOHN Sliding Fee Program
240 W. Front Street
Port Angeles, WA 98362
- Email: slidingfee@nohn-pa.org*

You will be contacted with a determination. In addition to our Sliding Fee Program, we also offer payment plans, with or without the discount from our Sliding Fee Program. To discuss options for a payment plan, please contact our Patient Accounts department at (360) 452-8086, option 1.

Frequently Asked Questions:

Who should I list as a member of my family/household?

Please list anyone related by blood, marriage, or adoption. This includes dependents such as children under the age of 19 (or 24 if a full-time student) as well as legally disabled adults.

What sources of income are required?

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

Examples include:

- Annual Social Security Statement
- Pay stubs for the last three 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 - *OR* - Three months of income and expense reports

Which bank statements are required?

All checking and savings accounts for the last three months are required. Please provide explanations for ALL deposits.

Examples Include:

- Repayment of a loan to a friend
- Family members use the bank account as well
- Family providing financial assistance to the applicant
- Refund from a prior purchase

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

Sliding Fee Program Application

If you have any questions concerning this application or required documentation, please contact our Fiscal Program Coordinator at (360) 452-8086, option 2.

PATIENT / APPLICANT INFORMATION

Applicant Name: _____ Birth Date: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Number: _____ Email: _____

How would you like your response letter to be sent? ☐ MyChart ☐ Mail ☐ Email

EMPLOYMENT STATUS OF THE PERSON RESPONSIBLE FOR PAYING THE BILL

☐ Employed (Date of Hire: _____) ☐ Unemployed (How long? _____)

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

FAMILY INFORMATION

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

NAME	DOB	RELATIONSHIP TO PATIENT	RECEIVING INCOME?	STUDENT	SOURCE OF INCOME
		Self	Y / N	Y / N	
			Y / N	Y / N	
			Y / N	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 the Last 3 Months
- ☐ Proof of Eligibility for Medicaid / TANF
- ☐ Other: _____

****If you have no proof of income or no income, please use the enclosed 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 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

Sliding Fee Program Services

As a Federally Qualified Healthcare Center, North Olympic Healthcare Network can discount services on a sliding fee scale according to your household income and family size.

Patients must apply and qualify to receive discounts on services. Sliding fee scales are included with the application materials. Staff are available to assist patients in determining their eligibility. Approval will be based on a review of your completed application and additional relevant materials.

Once approved, sliding fee discounts will be applied to the NOHN services available to you as a patient, including medical, dental, behavioral health, vision, and pharmacy services.

Sliding fee discounts are adjusted for certain services, and separate conditions and/or fees may apply:

Upper-Level Dental Services

In addition to preventive and restorative dentistry, we offer upper-level services such as root canals, crowns, and bridges.

- Service Fee: A nominal fee will apply for all upper-level services, due on the date of service.
- Dental Lab Costs: Some upper-level services may incur lab costs to produce materials. Lab fees are due prior to performing services. *Sliding fee discounts do not apply to lab costs.*

NOHN Pharmacy:

If a patient qualifies for the Sliding Fee Program discount and chooses to utilize Pharmacy Prescription Services, a coupon will be included with their approval letter. Patients must inform their healthcare provider that they would like to use this service in order to have all prescriptions switched to NOHN's on-site pharmacy.

Olympic Medical Center:

If a patient chooses to go to Olympic Medical Center (OMC) or one of its Specialty Clinics, the provider will generate an appropriate referral at an appointment. The patient's Sliding Fee Program tier will be noted on the chart. *OMC has a separate financial assistance program and application process that may have different guidelines for sliding scale. Patients may be referred to their financial department for further instruction.*

For more information, please visit www.nohn-pa.org/sliding-fee-program or scan the QR code below with your smartphone.



Sliding Fee Program Attestation Letter

Patient Name _____ Date _____

If you do not have income, please explain how you are managing to meet your essential needs, including housing and food.

Please provide contact information for someone who is not applying with whom we can verify the above statement. (*This contact person cannot be a NOHN employee.*)

Name _____ Relationship _____

Address _____ Phone # _____

City, ST, ZIP _____

Applicant Signature

Date

2025 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	100%	90%	80%	70%	60%		
Responsibility =	Discount	Discount	Discount	Discount	Discount	Discount	No Discount
1	Annual (up to)	\$15,650.00	\$19,562.50	\$23,475.00	\$27,387.50	\$31,300.00	\$31,301.00
	Monthly	\$1,304.17	\$1,630.21	\$1,956.25	\$2,282.29	\$2,608.33	\$2,608.42
	Weekly	\$300.96	\$376.20	\$451.44	\$526.68	\$601.92	\$601.94
2	Annual (up to)	\$21,150.00	\$26,437.50	\$31,725.00	\$37,012.50	\$42,300.00	\$42,301.00
	Monthly	\$1,762.50	\$2,203.13	\$2,643.75	\$3,084.38	\$3,525.00	\$3,525.08
	Weekly	\$406.73	\$508.41	\$610.10	\$711.78	\$813.46	\$813.48
3	Annual (up to)	\$26,650.00	\$33,312.50	\$39,975.00	\$46,637.50	\$53,300.00	\$53,301.00
	Monthly	\$2,220.83	\$2,776.04	\$3,331.25	\$3,886.46	\$4,441.67	\$4,441.75
	Weekly	\$512.50	\$640.63	\$768.75	\$896.88	\$1,025.00	\$1,025.02
4	Annual (up to)	\$32,150.00	\$40,187.50	\$48,225.00	\$56,262.50	\$64,300.00	\$64,301.00
	Monthly	\$2,679.17	\$3,348.96	\$4,018.75	\$4,688.54	\$5,358.33	\$5,358.42
	Weekly	\$618.27	\$772.84	\$927.40	\$1,081.97	\$1,236.54	\$1,236.56
5	Annual (up to)	\$37,650.00	\$47,062.50	\$56,475.00	\$65,887.50	\$75,300.00	\$75,301.00
	Monthly	\$3,137.50	\$3,921.88	\$4,706.25	\$5,490.63	\$6,275.00	\$6,275.08
	Weekly	\$724.04	\$905.05	\$1,086.06	\$1,267.07	\$1,448.08	\$1,448.10
6	Annual (up to)	\$43,150.00	\$53,937.50	\$64,725.00	\$75,512.50	\$86,300.00	\$86,301.00
	Monthly	\$3,595.83	\$4,494.79	\$5,393.75	\$6,292.71	\$7,191.67	\$7,191.75
	Weekly	\$829.81	\$1,037.26	\$1,244.71	\$1,452.16	\$1,659.62	\$1,659.63
7	Annual (up to)	\$48,650.00	\$60,812.50	\$72,975.00	\$85,137.50	\$97,300.00	\$97,301.00
	Monthly	\$4,054.17	\$5,067.71	\$6,081.25	\$7,094.79	\$8,108.33	\$8,108.42
	Weekly	\$935.58	\$1,169.47	\$1,403.37	\$1,637.26	\$1,871.15	\$1,871.17
8	Annual (up to)	\$54,150.00	\$67,687.50	\$81,225.00	\$94,762.50	\$108,300.00	\$108,301.00
	Monthly	\$4,512.50	\$5,640.63	\$6,768.75	\$7,896.88	\$9,025.00	\$9,025.08
	Weekly	\$1,041.35	\$1,301.68	\$1,562.02	\$1,822.36	\$2,082.69	\$2,082.71
Each Additional Person	Annual (up to)	\$5,500.00	\$6,875.00	\$8,250.00	\$9,625.00	\$11,000.00	\$11,001.00
	Monthly	\$458.33	\$572.92	\$687.50	\$802.08	\$916.67	\$916.75
	Weekly	\$105.77	\$132.21	\$158.65	\$185.10	\$211.54	\$211.56

2025 NOHN Upper Level Dental Services Sliding Fee Scale

The Nominal Fee and Lab fees are collected before the service start date and are not included in the scale calculations below. The remaining balance is billed to the patient after the service date.

Family Size	Category Slide >>	A	B	C	D	E	N/A
		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)	\$15,650.00	\$19,562.50	\$23,475.00	\$27,387.50	\$31,300.00	\$31,301.00
	Monthly	\$1,304.17	\$1,630.21	\$1,956.25	\$2,282.29	\$2,608.33	\$2,608.42
	Weekly	\$300.96	\$376.20	\$451.44	\$526.68	\$601.92	\$601.94
2	Annual (up to)	\$21,150.00	\$26,437.50	\$31,725.00	\$37,012.50	\$42,300.00	\$42,301.00
	Monthly	\$1,762.50	\$2,203.13	\$2,643.75	\$3,084.38	\$3,525.00	\$3,525.08
	Weekly	\$406.73	\$508.41	\$610.10	\$711.78	\$813.46	\$813.48
3	Annual (up to)	\$26,650.00	\$33,312.50	\$39,975.00	\$46,637.50	\$53,300.00	\$53,301.00
	Monthly	\$2,220.83	\$2,776.04	\$3,331.25	\$3,886.46	\$4,441.67	\$4,441.75
	Weekly	\$512.50	\$640.63	\$768.75	\$896.88	\$1,025.00	\$1,025.02
4	Annual (up to)	\$32,150.00	\$40,187.50	\$48,225.00	\$56,262.50	\$64,300.00	\$64,301.00
	Monthly	\$2,679.17	\$3,348.96	\$4,018.75	\$4,688.54	\$5,358.33	\$5,358.42
	Weekly	\$618.27	\$772.84	\$927.40	\$1,081.97	\$1,236.54	\$1,236.56
5	Annual (up to)	\$37,650.00	\$47,062.50	\$56,475.00	\$65,887.50	\$75,300.00	\$75,301.00
	Monthly	\$3,137.50	\$3,921.88	\$4,706.25	\$5,490.63	\$6,275.00	\$6,275.08
	Weekly	\$724.04	\$905.05	\$1,086.06	\$1,267.07	\$1,448.08	\$1,448.10
6	Annual (up to)	\$43,150.00	\$53,937.50	\$64,725.00	\$75,512.50	\$86,300.00	\$86,301.00
	Monthly	\$3,595.83	\$4,494.79	\$5,393.75	\$6,292.71	\$7,191.67	\$7,191.75
	Weekly	\$829.81	\$1,037.26	\$1,244.71	\$1,452.16	\$1,659.62	\$1,659.63
7	Annual (up to)	\$48,650.00	\$60,812.50	\$72,975.00	\$85,137.50	\$97,300.00	\$97,301.00
	Monthly	\$4,054.17	\$5,067.71	\$6,081.25	\$7,094.79	\$8,108.33	\$8,108.42
	Weekly	\$935.58	\$1,169.47	\$1,403.37	\$1,637.26	\$1,871.15	\$1,871.17
8	Annual (up to)	\$54,150.00	\$67,687.50	\$81,225.00	\$94,762.50	\$108,300.00	\$108,301.00
	Monthly	\$4,512.50	\$5,640.63	\$6,768.75	\$7,896.88	\$9,025.00	\$9,025.08
	Weekly	\$1,041.35	\$1,301.68	\$1,562.02	\$1,822.36	\$2,082.69	\$2,082.71
Each Additional Person	Annual (up to)	\$5,500.00	\$6,875.00	\$8,250.00	\$9,625.00	\$11,000.00	\$11,001.00
	Monthly	\$458.33	\$572.92	\$687.50	\$802.08	\$916.67	\$916.75
	Weekly	\$105.77	\$132.21	\$158.65	\$185.10	\$211.54	\$211.56

2025 NOHN Pharmacy Sliding Fee Scale

The Actual Acquisition Price of the drug is not included in the scale calculations below
(+)plus the NOHN Dispensing Fee of \$21.00 scaled calculations below.

Family Size	Category Slide >>	A	B	C	D	E	N/A
	POVERTY LEVEL	0-100%	101-125%	126-150%	151-175%	176-200%	>200%
1	Patient Responsibility =	100%	90%	80%	70%	60%	
	Annual (up to)	Discount	Discount	Discount	Discount	Discount	No Discount
	Monthly	\$15,650.00	\$19,562.50	\$23,475.00	\$27,387.50	\$31,300.00	\$31,301.00
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	Monthly	\$300.96	\$376.20	\$451.44	\$526.68	\$601.92	\$601.94
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	Monthly	\$105.77	\$132.21	\$158.65	\$185.10	\$211.54	\$211.56
	Weekly						