

NEW PATIENT REGISTRATION – CHILD (0-18YRS)

CHILD INFORMATION

First Name _____

Last Name _____

Sex: Male ☐ Female ☐ Date of Birth _____

Child's Social Security Number _____

PRIMARY INFORMATION *(where and whom the child lives with)*

Parent/Guardian Name _____

Social Security # _____ Date of Birth _____

Child lives with: Both Parents ☐ Mother ☐ Father ☐ Foster Parents ☐ Grandparents ☐ Legal Guardian ☐ Emancipated Minor ☐ Other _____

Child's Home Address _____

Mailing Address (if different than above)

Email Address _____ Contact Phone # _____

EMERGENCY CONTACT INFORMATION

Contact Name _____

Contact Phone # _____ Relationship _____

ASSISTANCE

Does the patient require language interpretation for appointments? ☐ Yes ☐ No

Does the patient require sign language interpretation for appointments? ☐ Yes ☐ No

Does the patient need transportation assistance to/for appointments? ☐ Yes ☐ No

PLEASE COMPLETE OTHER SIDE



PATIENT NAME _____ DATE OF BIRTH _____

FEES AND BILLING

No patient will be denied service due to inability to pay. We offer a Sliding Fee Discount program which can provide discount fees for certain services. To see if you qualify, please complete the information below.

Gross Monthly Household Income \$ _____

Number of Family Members in Your Household _____

I decline to see if I qualify for Sliding Fee Discount ☐

INSURANCE INFORMATION

Does the child have health insurance? Yes ☐ No ☐

If no, would you like information on signing up for health insurance? Yes ☐ No ☐

Insurance Name _____

Policy Number _____ Group # _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber relationship to child _____ Subscriber Social Security # _____

Subscriber Employer _____

Employers Address _____

Is there a secondary insurance? Yes ☐ No ☐

Insurance Name _____

Policy Number _____ Group Number _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber relationship to child _____ Subscriber Social Security # _____

Subscriber Employer _____

Employer's Address _____

NORTH OLYMPIC HEALTHCARE NETWORK
PEDIATRIC HEALTH QUESTIONNAIRE

DATE: _____ NAME (PRINT): _____

DATE OF BIRTH: _____ AGE: _____ SEX: ☐ M ☐ F

BIRTH HISTORY

1. Birthplace _____
2. Normal Pregnancy ☐ Yes ☐ No
3. Normal Delivery ☐ Yes ☐ No
4. Was baby full-term? ☐ Yes ☐ No

GROWTH AND DEVELOPMENT

1. Any development concerns? _____
 2. Number of years in school: _____
 3. Attends special school or classes? ☐ Yes ☐ No
 4. Discipline or behavior problems? ☐ Yes ☐ No
If yes, please explain: _____
-

PAST MEDICAL HISTORY

1. Please mark any of the listed major medical problems your child has: ☐ Asthma ☐ Allergies
☐ Depression ☐ Anxiety ☐ Diabetes ☐ Seizures ☐ Other _____
2. Please list any serious injuries your child has had: _____
3. Has your child had chicken pox? ☐ Yes ☐ No If yes, what age? _____
4. Had you child had any other contagious diseases (i.e.) measles, mumps, etc.? ☐ Yes ☐ No
If yes, please list: _____
5. Immunizations (Shots)

Please attach a vaccine history if available

MEDICATIONS

1. Please list all medications your child is currently taking: _____
-

HOSPITALIZATIONS

1. Please list any hospitalizations your child has had (when, where and why): _____
-

ALLERGIC REACTIONS

1. Does your child suffer from any allergic reactions (Drugs, Asthma, Hives, Eczema, Hay Fever, etc.)? _____
-

SOCIAL HISTORY

- Father's Age: _____ Health: ☐ Good ☐ Fair ☐ Poor ☐ Father is deceased
 - Mother's Age: _____ Health: ☐ Good ☐ Fair ☐ Poor ☐ Mother is deceased
 - Number of siblings: _____ Ages: _____
 - Who has legal custody of the child? _____
-

FAMILY HISTORY

1. Please mark any history in the family of the following diseases: ☐ Diabetes ☐ Heart Disease
☐ Cancer ☐ TB ☐ Convulsions ☐ Seizures ☐ Allergies ☐ Other _____



GENERAL

1. Is your child having currently having any specific issues or problems? ☐ Yes ☐ No

If yes, please list here: _____

ANY SPECIAL COMMENTS ABOUT YOUR CHILD

CHILD'S LAST DOCTOR

Please list your child's last doctor: _____

Who completed this form? _____

Relationship to child? _____

Signature: _____ Date: _____

PATIENT DEMOGRAPHIC QUESTIONNAIRE

Thank you for completing/reviewing this form. Your (voluntary) participation helps us better understand our patients and fulfill our mission as a community health center.

Date:

GENERAL INFORMATION (Fill out for self/patient)

Patient Legal First Name:	Last Name:	Preferred Name:	Date of Birth (patient):
1a. What is your (patient's) preferred language?		1b. Do you (patient) need an interpreter? ☐ Yes ☐ No	

HOUSING / INCOME (Fill out based on household information)

2. How many people are in your household, including yourself?	3. What is your annual household income (total combined for you and your household)? Depending on your income, you may be eligible for assistance. \$ _____		
	☐ \$0-15,500	☐ \$26,001-31,000	☐ \$55,001-64,000
	☐ \$15,501-20,000	☐ \$31,001-39,000	☐ \$64,001-85,000
	☐ \$20,001-26,000	☐ \$39,001-55,000	☐ \$85,001+
4. What is your housing situation today? I have steady housing: ☐ Own ☐ Rent			
I do not have steady housing:			
☐ Doubling Up (Couch Surfing)	☐ Homeless Shelter	☐ Street / Park / Car	
☐ Permanent Supportive Housing	☐ Transitional (Recovery Home)	☐ Other	
5. At any time in the past 2 years, has seasonal/migratory farm work been your or your family's main source of income? ☐ Yes ☐ No			
6. Are you (patient) a United States Armed Forces veteran? ☐ Yes ☐ No			

DEMOGRAPHIC INFORMATION (Fill out for self/patient)

7. What is your (patient's) sex?
8. Are you (patient) Hispanic and/or Latinx? ☐ Another Hispanic, Latinx or Spanish Origin ☐ Mexican, Mexican American, Chicanx ☐ Puerto Rican ☐ Cuban ☐ Not of Hispanic, Latinx or Spanish Origin
9. Describe your (patient) racial background. (American Indian, Black/African American, Chinese, Filipino, Japanese, Mam, White, etc.) _____

For Future Use: Please initial and date below once you have reviewed this form at each annual review.

_____ | _____ | _____ | _____ | _____

OFFICE USE ONLY	Completed By:	MRN:
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Patient Demographic Questionnaire

You may wonder why we need this information. North Olympic Healthcare Network is a **Federally Qualified Health Center (FQHC)**, a special type of community health center. We offer care to everyone, regardless of age, sex, ethnicity, or whether a patient has insurance or can afford to pay.

Your answers on this form help us:

- Understand our patients' emotional, financial and other needs
- Identify who may benefit from assistance
- Provide high-quality, personalized care
- Fulfill our mission as a community health center
- Meet our reporting requirements as an FQHC

Your Answers Are Secure

We keep your answers private and secure. We only report them in a way that does not identify individuals.

How to fill out the PDQ

Please read each question carefully and answer as best you can.

If you are filling out the form on behalf of another person (spouse, child, etc.):

- Please complete the **General Information** and **Demographic Information** sections based on the patient's information.
- Please complete the **Housing/Income** section based on the patient's household information.

Reviewing the PDQ Each Year

Once each year we will ask you to review the information on this form.

If there are no changes, please initial and date in the space at the bottom of the form.

If you need to make changes, please put a line through the previous answer and fill in the check box of the new, corrected answer. Then initial and date in the space at the bottom of the form.

Thank you for choosing North Olympic Healthcare Network for your healthcare needs!

CONSENT FOR TREATMENT OF A MINOR CHILD

At North Olympic Healthcare Network (NOHN), we require the consent of a parent or legal guardian to provide most types of routine care for patients under the age of 18. Having prior authorization in place allows us to deliver medical care to minors under the care of proxy decision maker if you, as the parent or legal guardian, cannot be present to provide consent. Please carefully review and complete this form if you would like us to care for your child when the child is brought in by another adult you choose.

Minor Patient Information

Minor Patient Name: _____ Date of Birth: _____

This authorization applies when an adult listed below brings the minor patient to a NOHN clinic:

Name of Adult	Relationship to Minor	Phone Number

Authorization to Treat a Minor Patient

I am the parent or legal guardian of the minor patient named above. I give advance authorization and consent for the minor patient receiving routine or emergency health care treatment considered necessary by clinical staff. This includes any care, service, or procedure provided by the clinical staff to diagnose, treat, or maintain physical or mental condition.

☐ By checking this box, I also give advance authorization and consent for the minor patient to receive vaccinations recommended by clinical staff.

I do not authorize the following kinds of medical services (List services you do not wish to authorize without your presence – if none, write “none”):

I, the parent or legal guardian, will communicate with the minor patient and adult listed above about the care provided, diagnostic findings, and treatment plan and I will follow up on any treatment plan and medications.

I, the parent or legal guardian, agree to assume financial responsibility for all expenses of the care provided. I may revoke this authorization at any time by contacting NOHN. I indemnify and hold harmless North Olympic Healthcare Network, and all its officers, agents, employees, directors, insurers, affiliates, from any and all liability for acting in reliance on this authorization.

This authorization will be valid until revoked by notifying North Olympic Healthcare Network (NOHN).

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date Signed: _____

Daytime Phone: _____ Evening Phone: _____

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 and *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 offer payment plans, with or without the Sliding Fee Program discount. To discuss payment plan options, 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.
- Applications expire on January 31st of each year when the new Federal Poverty Levels are updated by the government.

Do Not Write Below This Line – Administrative Use Only

Sliding Fee Program Services

As a Federally Qualified Healthcare Center, North Olympic Healthcare Network can offer discounted services on a sliding fee scale based on 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: The total patient responsibility and nominal fee of \$150.00 per tooth is due prior to scheduling the service.
- Dental Lab Costs: Some upper-level services may incur lab costs to produce materials. Lab fees are due before services are performed. *Sliding fee discounts do not apply to lab costs.*

NOHN Pharmacy:

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. The sliding fee discount is the Actual Acquisition Cost of the drug plus the Scale Discount, applied to the NOHN administrative fee of \$21.00, or your copay, whichever is less.

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, with different guidelines for the 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

2026 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%	90%	80%	70%	60%	No Discount
	=	Discount	Discount	Discount	Discount	Discount	No Discount
1	Annual (up to)	\$ 15,960.00	\$ 19,950.00	\$ 23,940.00	\$ 27,930.00	\$ 31,920.00	\$ 31,920.01
	Monthly	\$ 1,330.00	\$ 1,662.50	\$ 1,995.00	\$ 2,327.50	\$ 2,660.00	\$ 2,660.00
	Weekly	\$ 306.92	\$ 383.65	\$ 460.38	\$ 537.12	\$ 613.85	\$ 613.85
2	Annual (up to)	\$ 21,640.00	\$ 27,050.00	\$ 32,460.00	\$ 37,870.00	\$ 43,280.00	\$ 43,280.01
	Monthly	\$ 1,803.33	\$ 2,254.17	\$ 2,705.00	\$ 3,155.83	\$ 3,606.67	\$ 3,606.67
	Weekly	\$ 416.15	\$ 520.19	\$ 624.23	\$ 728.27	\$ 832.31	\$ 832.31
3	Annual (up to)	\$ 27,320.00	\$ 34,150.00	\$ 40,980.00	\$ 47,810.00	\$ 54,640.00	\$ 54,640.01
	Monthly	\$ 2,276.67	\$ 2,845.83	\$ 3,415.00	\$ 3,984.17	\$ 4,553.33	\$ 4,553.33
	Weekly	\$ 525.38	\$ 656.73	\$ 788.08	\$ 919.42	\$ 1,050.77	\$ 1,050.77
4	Annual (up to)	\$ 33,000.00	\$ 41,250.00	\$ 49,500.00	\$ 57,750.00	\$ 66,000.00	\$ 66,000.01
	Monthly	\$ 2,750.00	\$ 3,437.50	\$ 4,125.00	\$ 4,812.50	\$ 5,500.00	\$ 5,500.00
	Weekly	\$ 634.62	\$ 793.27	\$ 951.92	\$ 1,110.58	\$ 1,269.23	\$ 1,269.23
5	Annual (up to)	\$ 38,680.00	\$ 48,350.00	\$ 58,020.00	\$ 67,690.00	\$ 77,360.00	\$ 77,360.01
	Monthly	\$ 3,223.33	\$ 4,029.17	\$ 4,835.00	\$ 5,640.83	\$ 6,446.67	\$ 6,446.67
	Weekly	\$ 743.85	\$ 929.81	\$ 1,115.77	\$ 1,301.73	\$ 1,487.69	\$ 1,487.69
6	Annual (up to)	\$ 44,360.00	\$ 55,450.00	\$ 66,540.00	\$ 77,630.00	\$ 88,720.00	\$ 88,720.01
	Monthly	\$ 3,696.67	\$ 4,620.83	\$ 5,545.00	\$ 6,469.17	\$ 7,393.33	\$ 7,393.33
	Weekly	\$ 853.08	\$ 1,066.35	\$ 1,279.62	\$ 1,492.88	\$ 1,706.15	\$ 1,706.15
7	Annual (up to)	\$ 50,040.00	\$ 62,550.00	\$ 75,060.00	\$ 87,570.00	\$ 100,080.00	\$ 100,080.01
	Monthly	\$ 4,170.00	\$ 5,212.50	\$ 6,255.00	\$ 7,297.50	\$ 8,340.00	\$ 8,340.00
	Weekly	\$ 962.31	\$ 1,202.88	\$ 1,443.46	\$ 1,684.04	\$ 1,924.62	\$ 1,924.62
8	Annual (up to)	\$ 55,720.00	\$ 69,650.00	\$ 83,580.00	\$ 97,510.00	\$ 111,440.00	\$ 111,440.01
	Monthly	\$ 4,643.33	\$ 5,804.17	\$ 6,965.00	\$ 8,125.83	\$ 9,286.67	\$ 9,286.67
	Weekly	\$ 1,071.54	\$ 1,339.42	\$ 1,607.31	\$ 1,875.19	\$ 2,143.08	\$ 2,143.08
Each Additional Person	Annual (up to)	\$ 5,680.00	\$ 7,100.00	\$ 8,520.00	\$ 9,940.00	\$ 11,360.00	\$ 11,360.01
	Monthly	\$ 473.33	\$ 591.67	\$ 710.00	\$ 828.33	\$ 946.67	\$ 946.67
	Weekly	\$ 109.23	\$ 136.54	\$ 163.85	\$ 191.15	\$ 218.46	\$ 218.46

2026 NOHN Upper Level Dental Services Sliding Fee Scale

The total patient responsibility and nominal fee of \$150.00 per tooth is due prior to scheduling the service. Lab fees are collected prior to the service start date and are not included in the scale 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%
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)	\$ 15,960.00	\$ 19,950.00	\$ 23,940.00	\$ 27,930.00	\$ 31,920.00	\$ 31,920.01
	Monthly	\$ 1,330.00	\$ 1,662.50	\$ 1,995.00	\$ 2,327.50	\$ 2,660.00	\$ 2,660.00
	Weekly	\$ 306.92	\$ 383.65	\$ 460.38	\$ 537.12	\$ 613.85	\$ 613.85
2	Annual (up to)	\$ 21,640.00	\$ 27,050.00	\$ 32,460.00	\$ 37,870.00	\$ 43,280.00	\$ 43,280.01
	Monthly	\$ 1,803.33	\$ 2,254.17	\$ 2,705.00	\$ 3,155.83	\$ 3,606.67	\$ 3,606.67
	Weekly	\$ 416.15	\$ 520.19	\$ 624.23	\$ 728.27	\$ 832.31	\$ 832.31
3	Annual (up to)	\$ 27,320.00	\$ 34,150.00	\$ 40,980.00	\$ 47,810.00	\$ 54,640.00	\$ 54,640.01
	Monthly	\$ 2,276.67	\$ 2,845.83	\$ 3,415.00	\$ 3,984.17	\$ 4,553.33	\$ 4,553.33
	Weekly	\$ 525.38	\$ 656.73	\$ 788.08	\$ 919.42	\$ 1,050.77	\$ 1,050.77
4	Annual (up to)	\$ 33,000.00	\$ 41,250.00	\$ 49,500.00	\$ 57,750.00	\$ 66,000.00	\$ 66,000.01
	Monthly	\$ 2,750.00	\$ 3,437.50	\$ 4,125.00	\$ 4,812.50	\$ 5,500.00	\$ 5,500.00
	Weekly	\$ 634.62	\$ 793.27	\$ 951.92	\$ 1,110.58	\$ 1,269.23	\$ 1,269.23
5	Annual (up to)	\$ 38,680.00	\$ 48,350.00	\$ 58,020.00	\$ 67,690.00	\$ 77,360.00	\$ 77,360.01
	Monthly	\$ 3,223.33	\$ 4,029.17	\$ 4,835.00	\$ 5,640.83	\$ 6,446.67	\$ 6,446.67
	Weekly	\$ 743.85	\$ 929.81	\$ 1,115.77	\$ 1,301.73	\$ 1,487.69	\$ 1,487.69
6	Annual (up to)	\$ 44,360.00	\$ 55,450.00	\$ 66,540.00	\$ 77,630.00	\$ 88,720.00	\$ 88,720.01
	Monthly	\$ 3,696.67	\$ 4,620.83	\$ 5,545.00	\$ 6,469.17	\$ 7,393.33	\$ 7,393.33
	Weekly	\$ 853.08	\$ 1,066.35	\$ 1,279.62	\$ 1,492.88	\$ 1,706.15	\$ 1,706.15
7	Annual (up to)	\$ 50,040.00	\$ 62,550.00	\$ 75,060.00	\$ 87,570.00	\$ 100,080.00	\$ 100,080.01
	Monthly	\$ 4,170.00	\$ 5,212.50	\$ 6,255.00	\$ 7,297.50	\$ 8,340.00	\$ 8,340.00
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	Weekly	\$ 109.23	\$ 136.54	\$ 163.85	\$ 191.15	\$ 218.46	\$ 218.46

2026 NOHN Pharmacy Sliding Fee Scale

Actual Acquisition Price of drug + Scale Discount to the NOHN Administrative Fee of \$21.00, or Copay amount, whichever is less.

Category Slide >>	A	B	C	D	E	N/A
POVERTY LEVEL	0-100%	101-125%	126-150%	151-175%	176-200%	>200%
Family Size	Patient Responsibility	100%	90%	80%	70%	60%
=	Discount	Discount	Discount	Discount	Discount	No Discount
1	Annual (up to)	\$ 15,960.00	\$ 19,950.00	\$ 23,940.00	\$ 27,930.00	\$ 31,920.00
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5	Annual (up to)	\$ 38,680.00	\$ 48,350.00	\$ 58,020.00	\$ 67,690.00	\$ 77,360.00
	Monthly	\$ 3,223.33	\$ 4,029.17	\$ 4,835.00	\$ 5,640.83	\$ 6,446.67
	Weekly	\$ 743.85	\$ 929.81	\$ 1,115.77	\$ 1,301.73	\$ 1,487.69
6	Annual (up to)	\$ 44,360.00	\$ 55,450.00	\$ 66,540.00	\$ 77,630.00	\$ 88,720.00
	Monthly	\$ 3,696.67	\$ 4,620.83	\$ 5,545.00	\$ 6,469.17	\$ 7,393.33
	Weekly	\$ 853.08	\$ 1,066.35	\$ 1,279.62	\$ 1,492.88	\$ 1,706.15
7	Annual (up to)	\$ 50,040.00	\$ 62,550.00	\$ 75,060.00	\$ 87,570.00	\$ 100,080.00
	Monthly	\$ 4,170.00	\$ 5,212.50	\$ 6,255.00	\$ 7,297.50	\$ 8,340.00
	Weekly	\$ 962.31	\$ 1,202.88	\$ 1,443.46	\$ 1,684.04	\$ 1,924.62
8	Annual (up to)	\$ 55,720.00	\$ 69,650.00	\$ 83,580.00	\$ 97,510.00	\$ 111,440.00
	Monthly	\$ 4,643.33	\$ 5,804.17	\$ 6,965.00	\$ 8,125.83	\$ 9,286.67
	Weekly	\$ 1,071.54	\$ 1,339.42	\$ 1,607.31	\$ 1,875.19	\$ 2,143.08
Each Additional Person	Annual (up to)	\$ 5,680.00	\$ 7,100.00	\$ 8,520.00	\$ 9,940.00	\$ 11,360.00
	Monthly	\$ 473.33	\$ 591.67	\$ 710.00	\$ 828.33	\$ 946.67
	Weekly	\$ 109.23	\$ 136.54	\$ 163.85	\$ 191.15	\$ 218.46