OFFICAL USE ONLY:
DATE APPLICATION WILL EXPIRE: _____

Willamette Family Medical Center - Sliding Fee Discount Program

Willamette Family Medical Center (WFMC) is dedicated to providing quality healthcare services, education, and guidance in promoting health and wellness to all patients regardless of language or financial barriers; WFMC will not turn anyone away due to inability to pay. A patient who is uninsured or underinsured, may qualify for a sliding fee for their primary care and behavioral health services. Patients will be expected to pay the discounted rate that they qualify for. If they cannot pay at the time of service, they will need to make arrangement for payments.

Eligibility Criteria

The Sliding Fee Discount Program is based on the patient's income eligibility and family size. Patients may qualify for up to a 100% discount. WFMC will not discriminate on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin. The US Federal Poverty Guidelines are used in creating WFMC Sliding Fee Schedule. The schedule is updated on an annual basis to match the current US guidelines.

Note: This discount applies to primary care and behavioral health services provided at WFMC; the clinic may be able to help arrange a reduced fee for laboratory tests. You must make separate arrangements to pay for non-primary care or behavioral health services, including but not limited to: procedures, x-rays, ultrasounds, specialists, or hospitalizations. Further, WFMC encourages patients to access the clinic's social service programs to get help with applying for community financial assistance programs that may further discount their healthcare costs.

Criteria considered in determining eligibility for a sliding fee include, but are not limited to:

- The household's gross income, based on total family members.
- The patient's employment status and capacity for future earnings.
- Other living expenses & financial obligations.
- The family's monthly out of pocket expenses for medical supplies and services.

Supporting documentation may include the following:

- One month income verification (prior month of date applying) in the form of pay stubs, bank deposits, etc.
- Social Security determination letters
- The prior year's tax returns
- A "Statement of Sustainability" that indicates how persons with no income are meeting their day to day basic living needs.

There is a minimum fee of $35.00 for each visit. Any qualifying discounts are applied to the remaining balance of the visit fees. This balance is the patient's responsibility and will be billed to the patient.

To apply the patient must complete WFMC's Sliding Fee Application and return it within 30 business days of the stamped date. Until this process is completed, the patient will be responsible for the full charges. The sliding fee is valid for **six months** from the date of the application. To continue receiving a sliding fee you must re-apply and furnish proof of income.

For any questions regarding this policy or any other policies of WFMC, please contact the WFMC Administration Department at (503) 585-6388.

Revised: September 2017

Willamette Family Medical Center

Application for Sliding Fee

Today's date: _____

Head of household:

Last name	First name	MI	Social Security no.

Street address	Date of birth

City	State	Zip	Home phone no.

Head of household gross monthly income: $_____

Other family members:

Name	Date of birth	Gross monthly income
		$
		$
		$
		$
		$

For additional family member(s) please use the back of this form.

Total family gross monthly income: $_____

Total family members: _____

By signing this form, I attest to the truthfulness and completeness of all information requested.

Signature	Date

DO NOT WRITE BELOW THIS LINE (OFFICE USE ONLY)

Proof of income documents received:

[ ] Pay stubs [ ] Prior year tax returns [ ] Social Security determination letter

[ ] Bank deposits [ ] Statement of sustainability

A copy of each document must be attached to this application.

Eligible for discount of: _____% Beginning: _____ Ending: _____

Signature of staff	Date

WILLAMETTE FAMILY MEDICAL CENTER

Financial Disclosure- Confidential

[To be completed in full] **LIABILITIES**

List names of Firms	Unpaid Balance	Monthly Payment
Rent____ Own____		
Bank Loans		
Finance Companies		
Credit Union Loans		
Medical Expenses		
Personal Loans		
Collection Agencies		
Charge Accounts/Credit Cards		
Expenses:		
Food		
Utilities		
Phone		
Auto Expenses		
Health Insurance		
Auto Insurance		
Child Care		
Miscellaneous (please describe)		

I certify that all information listed herein is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services, which are rendered to me by Willamette Family Medical Center. I hereby grant permission to Willamette Family Medical Center to receive, release, or act upon financial information, to investigate the information contained herein. Investigation shall contain contacting, by written communication or telephone, of those persons, firms, corporations, etc. noted by you on this financial information document. Investigation may also include a credit check. I hereby release the designated clinic personnel and all parties who supply information at the request of clinic personnel from liability for any acts of commission or omission, communications or disclosures that are made pursuant to such an investigation. I understand that submission of false information will automatically disqualify me for any type of assistance.

Responsible Party Signature:_____ Date:_____

Spouse Signature: _____ Date:_____

Statement of Sustainability

Please fill out this statement of sustainability if you cannot provide any proof of income. Please indicate how persons with no income are meeting their day to day basic living needs. This will enable Willamette Family Medical Center to process your sliding fee application.

By signing this form, I attest to the truthfulness and completeness of all information requested.

Signature _____ Date _____

2017 Sliding Fee Schedule

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	100%	138%	150%	200%	250%	300%
	Charge					
Family Size	Nominal Fee ($35)	20% of visit	40% of visit	60% of visit	80% of visit	100% of visit
1	0-$12,060	$ 16,643	$ 18,090	$ 24,120	$ 30,150	$ 36,180
2	0-$16,240	$ 22,411	$ 24,360	$ 32,480	$ 40,600	$ 48,720
3	0-$20,420	$ 28,180	$ 30,630	$ 40,840	$ 51,050	$ 61,260
4	0-$24,600	$ 33,948	$ 36,900	$ 49,200	$ 61,500	$ 73,800
5	0-$28,780	$ 39,716	$ 43,170	$ 57,560	$ 71,950	$ 86,340
6	0-$32,960	$ 45,485	$ 49,440	$ 65,920	$ 82,400	$ 98,880
7	0-$37,140	$ 51,253	$ 55,710	$ 74,280	$ 92,850	$ 111,420
8	0-$41,320	$ 57,022	$ 61,980	$ 82,640	$ 103,300	$ 123,960

Add $4,180 for each person over 8

** Based on 2017 Federal Poverty Guidelines*