WFMC Health

Welcoming you …

OFFICAL USE ONLY:
DATE APPLICATION WILL EXPIRE: _____

WFMC Health – Financial Assistance Program

WFMC Health 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 Health will not turn anyone away due to inability to pay. Patients who are uninsured, may qualify for a sliding fee for their primary care and behavioral health services.

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 Health 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 Health 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 Health. Services such as labs and procedures are not eligible for discounts under this program. WFMC Health encourages patients to access the clinic's social service programs and can 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. WFMC will work with patients needing further assistance with paying for their healthcare costs.

To apply the patient must complete WFMC Health'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 Health, please contact the WFMC Health Administration Department at (503) 585-6388.

Revised: September 2020

WFMC Health Financial Assistance Application – Confidential

Please Note: Once you send in your application, we may check all the information and may ask for additional information or proof of income. Once your application has been processed, we will notify you if you qualify for assistance.

Assistance requested for: ☐ **Behavioral Health Services** ☐ **Primary Care Services**

Patient and Applicant Information	
Patient **Last Name**	Patient **First Name, Middle Initial**
Gender: ☐ Male ☐ Female ☐ Other (may specify) _____	Date of Birth (MM/DD/YYYY):

Head of Household Information	
Last Name:	First Name:
Relationship to Patient:	Date of Birth (MM/DD/YYYY):
Main Phone Number: ( ) _____ May we text this number? ☐ Yes ☐ No Email Address: _____	
Mailing Address _____ _____ _____ City State Zip Code	
Employment Status for Head of Household: ☐ **Employed** (Date of Hire:) ☐ **Unemployed** ☐ **Self Employed** ☐ **Student** ☐ **Disabled** ☐ **Retired** ☐ **Other** (_____)	

Family Information

Please list family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. Please attached additional pages if needed.

FAMILY SIZE: _____

Name	Date of Birth	Relationship to Patient	If 18 years or older: Total Gross monthly income (before taxes)	Also applying for financial assistance?
				Yes / No
				Yes / No
				Yes / No
				Yes / No

Income Information

Income verification is required to determine financial assistance. All family members 18 years or older must disclose their income. If you are unable to provide documentation, please submit a written signed statement describing your income. Please provide proof of every identified source of income. Examples of proof of income include:

- Current Pay Stubs or Bank Deposits (3 months)
- Last year's income tax return
- W-2 withholding statement
- Social Security or Disability Determination Letter
- Sustainability form (if you do not have proof of income or no income)

Patient Agreement

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____
Printed Name

_____ _____
Signature Date

FOR OFFICE USE ONLY (DO NOT WRITE BELOW THIS LINE):

Proof of Income Received:
☐ Pay stubs ☐ Tax Returns ☐ Bank Deposits ☐Social Security/Disability Determination
☐Bank Deposits ☐ Statement of Sustainability

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

_____ _____
Signature of Staff Date

Sustainability Form
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.