## Sliding Fee Discount Program Application

Applicant Name: _____ Birth Date: _____

Mailing Address: _____

City: _____ State: Zip Code: _____

Preferred Contact Number: _____ Email: _____

### FAMILY INFORMATION

| NAME | DOB | RELATIONSHIP TOPATIENT | RECEIVING INCOME | STUDENT | SOURCE OF INCOME |
|---|---|---|---|---|---|
| | | Self | Y/N | Y/N | |
| | | | Y/N | Y/N | |
| | | | Y/N | Y/N | |
| | | | Y/N | Y/N | |

### INCOME

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 that are applicable:

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

If you have no proof of income or no income, please use the enclosed attestation for explanation.

LEHD uses monthly gross income to project annual gross income. Annual gross income is used to determine eligibility for discounted services.
Approved proof of income sources includes most recent tax returns, paycheck stubs for 3 months, statement of income determination from federal, state, or local government (such as SSI letter).

I certify that the information given on this form and the income provided documentation is complete, true and correct. If I do not qualify for financial assistance, I agree to pay the outstanding balance in full. I agree and understand that any remaining balance not paid through financial assistance will be my responsibility and paid in full. I understand that financial assistance may not apply to all the services provided at LEHD. If account balances are not paid, I agree to pay the resulting collection charges, legal fees, and understand that access to LEHD services may be terminated. I understand that financial assistance may expire on or before the date indicated below and I will be required to reapply. If there is a change in income, I will submit a new Financial Assistance Application that defines family household members as anyone including self, spouse or partner, and dependent children under 18 years of age, and anyone within the residence

**Signature:** _____ **Date:** _____

**Employee verifying eligibility:** _____

**You qualified for the following discount:**

Category 1 Category 2 Category 3 Category 4 Category 5- Or no proof of Income

**Financial Assistance approved until** **Date:** _____

Thank you for choosing Lower Elwha Health Clinic as your health care provider and thank you for filling out the required forms and bringing the required documentation. Based upon the category indicated on the face of this document, please see below for discount details.

**If Category 1 is** circled, then:
For **Medical** care, you will be responsible to pay $20 for each time of service.
For **Dental** care, you will be responsible to pay $20 for each time of service.
For **Mental Health** services you will be responsible to pay $20 for each time of service.
For **SUD** services you will be responsible to pay $20 for each time of service.

**If Category 2 is circled, then:**
For **Medical** care. you will be responsible to pay $30.00 for each time of service.
For **Dental** care, you will be responsible to pay $30.00 for each time of service.
For **Mental Health** services, you will be responsible to pay $30.00 for each service.
For **SUD** services you will be responsible to pay $30.00 for each time of service.

**If Category 3 is circled,** then:
For **Medical** care, you will be responsible to pay $40.00 for each time of service.
For **Dental** care, you will be responsible to pay $40.00 for each time of service.
For **Mental Health** services, you will be responsible to pay $40.00 for each time of service.
**For SUD** services, you will be responsible to pay $40.00 for each time of service.

**If Category 4 is circled, then:**
For **Medical** care, you will be responsible to pay $50.00 for each time of service.
For **Dental** care, you will be responsible to pay $50.00 for each time of service.
For **Mental Health** services, you will be responsible to pay $50.00 for each time of service.
For **SUD** services you will be responsible for $50.00 for each time of service.

**If Category 5 is circled, then:**
For **Medical** care, you will be responsible for the full fee for each time of service.
For **Dental care,** you will be responsible to pay full fee for each time of service.
For **Behavioral Health** services, you will be responsible to pay full fee for each time of service.
For **SUD** services, you will be responsible to pay full fee for each time of service.

A deposit is required for each visit based on services scheduled in each department.
Any remaining balance will be billed after you're your visit.

**No Proof of Income**
If you choose not to bring in income verification within 3 business days of this application, we are unable to offer you discounted fees for service. A deposit is required for each visit based on services scheduled in each department. Any remaining balance will be billed after you're your visit.

Payment plans can be arranged through the Billing Department at (360) 452-6252 option 9
You may qualify for medical insurance. Please call (360) 452-6252 to meet with an enrollment specialist

**Lower Elwha Health Department**

Sulydwh#Sd|#Vdgjj#Ehh#Surjudp #Jxlghdqhv#

Eligibility is determined based on the current poverty guidelines relating to income and family size as listed in the HHS Poverty Guidelines and updated annually
2026 Federal Poverty Level Standards | Guidance Portal

| Annual Income | | | | | |
|---|---|---|---|---|---|
| **Family Size** | **100% FPL** | **133%FPL** | **166% FPL** | **200% FPL** | **201% FPL** |
| I | $15,960 | $21.227 | $26,494 | $31,920 | $32,080 |
| 2 | $21,640 | $28,781 | $35,922 | $43,280 | $43,496 |
| 3 | $27,320 | $36,336 | $45,351 | $54,640 | $54,913 |
| 4 | $33,000 | $43,890 | $54,780 | $66,000 | $66,330 |
| 5 | $38,680 | $51,444 | $64,209 | $77,360 | $77,747 |
| 6 | $44,360 | $58,999 | $73,638 | $88,720 | $89,164 |
| 7 | $50,040 | $66,553 | $83,066 | $100,080 | $100,580 |
| 8 | $55,720 | $74,108 | $92,495 | $111,440 | $111,997 |
| **Each additional person** | +$5,680 | +$7,554 | +$9,429 | +$11,360 | +$11,417 |

## Lower Elwha Health Department Sliding Fee Discount Program Application

## Attestation Letter

Patient Name _____ Date _____

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

_____

_____

_____

_____

_____

_____

_____

_____

Please provide contact Information for someone who is not applying with whom we can verify the above statement

Name _____ Relationship _____

Address _____ Phone# _____

City, ST, ZIP _____

_____

**Applicant Signature** **Date**