Sliding Fee Application

The Sliding Fee Program provides assistance with medical bills for those who qualify. To apply, complete this Sliding Fee Application and return with required documentation.

Client Information				
	Date of Request:	/ /	**DOB:**	/ /
	Full Name:		**SSN #:**	- -
	Home Phone:	( )	**Cell Phone:**	( )
	Mailing Address:			
	Marital Status:	❑ Single ❑ In a Relationship ❑ Married ❑ Divorced ❑ Separated ❑ Widowed		

Please list all household members including minor children under 21 that live with you (even if they are not applying for Sliding Fee Discount at this time.) If more space is required, use an additional sheet.

First and Last Name	Date of Birth	SSN #	Relationship to Client
	/ /	- -	
	/ /	- -	
	/ /	- -	
	/ /	- -	
	/ /	- -	

Income	$ Amount	Frequency (Weekly, Monthly)
Wages:		
Self-Employment:		
Social Security:		
Unemployment Compensation:		
Other (please specify):		
Your Estimated Annual Income:		

Please return copies of the following documents with this completed Sliding Fee Application:

- 1 month of wage/income statements
- If unemployed, please provide all sources of other income, such as (but not limited to): Unemployment Award Letter, Social Security/Disability Benefit Letter, etc.
- Other forms of income that may apply to you, such as: alimony, child support, military family allotments, pensions, IRA, retirement, annuities, income from rent, income from dividends or interest
- A copy of your most recent income tax return which indicates gross income (this is not required but helpful in making a determination of your application)
- If you are self-employed, you MUST include a copy of your most current income tax return and a copy of the following forms that apply to your type of self-employment business:
    - Schedule C Net Profit or Loss from Business (if applicable)
    - Form 8825 Profit or Loss from Rental Income (if applicable)
    - Form 8825 Net Rental Real Estate Income (if applicable)
    - Schedule F Profit or Loss from Farming (if applicable)

  Note: Based on review of income, you may be asked to submit Medicaid status information.

I certify that the information is true and accurate to the best of my knowledge. I understand that this application is made so that Community Integrated Health Services, LLC can determine my eligibility for Sliding Fee Discounts. I understand that this information may be used in discussions with another party to help determine eligibility.

Client Signature _____ Date _____

The following income guideline may help determine if you are eligible for Community Integrated Health Services, LLC's Sliding Fee Discount program. The intent of providing the following information is to enable you to determine if you or your household may be eligible for this program. If you are in doubt, we encourage you to submit this application for consideration.

2023 Financial Assistance Approval Guidelines

Family Size	100%	101-140%	141-180%	181-220%	221-260%	261-300%	301-340%	341-400%
1	$14,580	$14,581-$20,412	$20,413-$26,244	$26,245-$32,076	$32,077-$37,908	$37,909-$43,740	$43,741-$49,572	$49,573-$58,320
2	$19,720	$19,721-$27,608	$27,609-$35,496	$35,497-$43,384	$43,385-$51,272	$51,273-$59,160	$59,161-$67,048	$67,049-$78,880
3	$24,860	$24,861-$34,804	$34,805-$44,748	$44,749-$54,692	$54,693-$64,636	$64,637-$74,580	$74,581-$84,524	$84,525-$99,440
4	$30,000	$30,001-$42,000	$42,001-$54,000	$54,001 – $66,000	$66,001-$78,000	$78,001-$90,000	$90,001-$102,000	$102,001-$120,000
5	$35,140	$35,141-$49,196	$49,197-$63,252	$63,253-$77,308	$77,309-$91,364	$91,365-$105,420	$105,421-$119,476	$119,477-$140,560
6	$40,280	$40,281-$56,392	$56,393-$72,504	$72,505-$88,616	$88,617-$104,728	$104,729-$120,840	$120,841-$136,952	$136,953-$161,120
7	$45,420	$45,421-$63,588	$63,589-$81,756	$81,757-$99,924	$99,925-$118,092	$118,093-$136,260	$136,261-154,428	$154,429-$181,680
8	$50,560	$50,561-$70,784	$70,785-$91,008	$91,009-$111,232	$111,233-$131,456	$131,457-$151,680	$151,681-$171,904	$171,905-$202,240
+person	$5,140	$5,140	$7,196	$9,252	$11,308	$13,364	$15,420	$17,476
Discount	**100%**	**95%**	**90%**	**80%**		**60%**		
Example: A one-person household with a gross annual income of $28,000 falls between the $26,245-$32,076 range (or 181-220% of the national poverty limit) and would receive a sliding fee discount of 80%.								

Please mail completed application and necessary documents to:
Accounting Claims Department
Community Integrated Health Services, LLC
PO Box 1447, Chehalis, WA 98532
For more information, please call: 360.261.9630

Incomplete applications will be returned unprocessed.
Only services provided less than 3 months before application will be considered.

FOR OFFICE USE ONLY:

Date Received: / /	**Received by:**
Determination or Decision: ❑ Approved ❑ Denied	**Reviewed by:**
Reason for Decision:	
Sliding Fee Discount: %	**Entered by:**
Applicant Advised By Letter on: / /	**Sent by:**

COMMUNITY INTEGRATED
Health Services

Statement of Financial Eligibility

Thank you for choosing Community Integrated Health Services (CIHS) for your healthcare needs. We are committed to providing you with the highest quality of care. Please read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The client (or client's guardian) is responsible for payment of treatment and care.

- As a courtesy we will bill your insurance for you. Please notify us of any changes in coverage immediately
- You are responsible for copays, coinsurance, deductibles and all other services not covered by insurance
- Copays are due at the time of service
- If you are a Non-Medicaid client, you will be charged for No Shows or Cancellations without 24hr Notice
- You will be charged a $35 NSF fee for a check returned by your bank for any reason

My signature below acknowledges that I understand and agree to the terms above.

_____ _____

Signature Date

_____

Print Name

Assignment of Benefits

I hereby authorize any insurance carrier, including but not limited to Medicare or Medicaid, to make payment directly to CIHS for any services rendered to me, or my covered dependents.

_____ _____

Signature Date

_____

Print Name