



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: <input type="checkbox"/> Single <input type="checkbox"/> In a Relationship <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> 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.

2025 Financial Assistance Approval Guidelines

| Family Size | 100% | 101-140% | 141-180% | 181-220% | 221-260% | 261-300% | 301-340% | 341-400% |
|--|-------------|-----------------------|-----------------------|------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 1 | \$15,060 | \$15,061- \$21,084 | \$21,085- \$27,108 | \$27,109- \$33,132 | \$33,133- \$39,156 | \$39,157- \$45,180 | \$45,181- \$51,204 | \$51,205- \$60,240 |
| 2 | \$20,440 | \$20,441- \$28,616 | \$28,617- \$36,792 | \$36,793- \$44,968 | \$44,969- \$53,144 | \$53,145- \$61,320 | \$61,321- \$69,496 | \$69,497- \$81,760 |
| 3 | \$25,820 | \$25,821- \$36,148 | \$36,149- \$46,476 | \$46,477- \$56,804 | \$56,805- \$67,132 | \$67,133- \$77,460 | \$77,461- \$87,788 | \$87,789- \$103,280 |
| 4 | \$31,200 | \$31,201- \$43,680 | \$43,681- \$56,160 | \$56,161- \$68,640 | \$68,641- \$81,120 | \$81,121- \$93,600 | \$93,601- \$106,080 | \$106,081- \$124,800 |
| 5 | \$36,580 | \$36,581- \$51,212 | \$51,213- \$65,844 | \$65,845- \$80,476 | \$80,477- \$95,108 | \$95,109- \$109,740 | \$109,741- \$124,372 | \$124,373- \$146,320 |
| 6 | \$41,960 | \$41,961- \$58,744 | \$58,745- \$75,528 | \$75,529- \$92,312 | \$92,313- \$109,096 | \$109,097- \$125,880 | \$125,881- \$142,664 | \$142,665- \$167,840 |
| 7 | \$47,340 | \$47,341- \$66,276 | \$66,277- \$85,212 | \$85,213- \$104,148 | \$104,149- \$123,084 | \$123,085- \$142,020 | \$142,021- \$160,956 | \$160,957- \$189,360 |
| 8 | \$52,720 | \$52,721- \$73,808 | \$73,809- \$94,896 | \$94,897- \$115,984 | \$115,985- \$137,072 | \$137,073- \$158,160 | \$158,161- \$179,248 | \$179,249- \$210,880 |
| +person | \$5,380 | \$5,380 | \$7,532 | \$9,684 | \$11,836 | \$13,988 | \$16,140 | \$18,292 |
| Discount | 100% | 95% | 90% | 80% | | 60% | | |
| Example: A one-person household with a gross annual income of \$28,000 falls between 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: | <input type="checkbox"/> Approved <input type="checkbox"/> Denied | Reviewed by: |
| Reason for Decision: | | |
| Sliding Fee Discount: | % | Entered by: |
| Applicant Advised By Letter on: | / / | Sent by: |