



Discounted Fee Application

Community Health of Central Washington through its clinics provides discounted medical services for families at or below 200% of the federal poverty level. If you think you may qualify, fill out the application completely and provide all the necessary documentation described below.

Patient Name: _____ Phone Number: _____ Date: _____
 Birth Date: _____

Household Income: Includes the total compensation, welfare, disability, and other payments received from all members within the household.

Total household income: \$ _____

Family Size: List the names of each family member living within your household.

Family Member Name	Relationship	Birth date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total Family Size: _____ *If more than three list on back*

Verification: Please provide the following documents:

- Previous year's income tax return
- Pay stub from the **most recent 3 months** from each member of the household
- Any paperwork previously verified from the State or Federal Government:
 - State / Federal application of Aid (Medicaid, food stamps, etc.)
 - Unemployment or disability benefits
 - Other (i.e. Student's grant information, etc.)
 - Social Security income letter for current year
- Letter from employer verifying income with employer's contact information
- Letter from Court showing child support or alimony or other payments

I prefer to not state my family's size and annual income. ***I understand that I am responsible for the full charge for all services rendered at the clinics of Community Health of Central Washington; and that I must pay for the services on the day I receive them.***

I attest that the information provided above is true and correct. I understand that all discounts are contingent upon verification of required documentation. I further understand that if I do not provide necessary documentation at the time of service, I have 30 business days from the date of this application to provide documents or make arrangements with the Financial Counselor or I will be billed the full amount for services rendered.

Signature of Patient / Guardian

Date

Witness

Financial Counselor: _____

Disclaimer: Community Health of Central Washington has established arrangements with Yakima Valley Memorial Hospital, Yakima Regional Medical and Cardiac Hospital, Kittitas Valley Community Hospital, Pathology Associates, Medical Center Lab, Valley Imaging Partners and Yakima Valley Radiology to provide optimal Discounted Fee Program to our patients at or below the poverty level.

Discounted Fee Program

January 1, 2016 – December 31, 2016

CHCW's standard fees are discounted based on the current Department of Health and Human Services Federal Poverty Guidelines, as follows.

2016 CHCW Sliding Fee Discount Program									
Effective 1/1/2016									
Family/Household	SFSD A		SFSD B		SFSD C		SFSD D		Self-Pay Patients
	0 - 100% Poverty Level		101% - 133%		133.1% - 166%		166.1% - 200%		Over 200% of FPL
1	0	\$11,880	\$ 11,881	\$ 15,800	\$ 15,801	\$ 19,721	\$ 19,722	\$ 23,760	\$ 23,761
2	0	\$16,020	\$ 16,021	\$ 21,307	\$ 21,308	\$ 26,593	\$ 26,594	\$ 32,040	\$ 32,041
3	0	\$20,160	\$ 20,161	\$ 26,813	\$ 26,814	\$ 33,466	\$ 33,467	\$ 40,320	\$ 40,321
4	0	\$24,300	\$ 24,301	\$ 32,319	\$ 32,320	\$ 40,338	\$ 40,339	\$ 48,600	\$ 48,601
5	0	\$28,440	\$ 28,441	\$ 37,825	\$ 37,826	\$ 47,210	\$ 47,211	\$ 56,880	\$ 56,881
6	0	\$32,580	\$ 32,581	\$ 43,331	\$ 43,332	\$ 54,083	\$ 54,084	\$ 65,160	\$ 65,161
7	0	\$36,730	\$ 36,731	\$ 48,851	\$ 48,852	\$ 60,972	\$ 60,973	\$ 73,460	\$ 73,461
8	0	\$40,890	\$ 40,891	\$ 54,384	\$ 54,385	\$ 67,877	\$ 67,878	\$ 81,780	\$ 81,781
9	0	\$45,050	\$ 45,051	\$ 59,917	\$ 59,918	\$ 74,783	\$ 74,784	\$ 90,100	\$ 90,101
10	0	\$49,210	\$ 49,211	\$ 65,449	\$ 65,450	\$ 81,689	\$ 81,690	\$ 98,420	\$ 98,421
11	0	\$53,370	\$ 53,371	\$ 70,982	\$ 70,983	\$ 88,594	\$ 88,595	\$ 106,740	\$ 106,741
12	0	\$57,530	\$ 57,531	\$ 76,515	\$ 76,516	\$ 95,500	\$ 95,501	\$ 115,060	\$ 115,061
More than 12		add \$4,160 for each additional person							
Medical Services Discount	\$20 Nominal Fee	60% Discount		40% Discount		20% Discount		None	
Dental Services Discount	\$45 Nominal Fee	55% Discount		40% Discount		20% Discount		None	
Mental Health Services	\$20 Nominal Fee	\$20 Visit Charge		\$20 Visit Charge		\$20 Visit Charge		\$20 Visit Charge	

*Excluded services – Pharmacy, prosthetics, dentures, bleaching, circumcision, contraception, cosmetic surgery, vaccines and services provided by other providers who are not part of CHCW. Services discounted separately; Laboratory services, ordered by PAML, Comprehensive Mental Health Psychiatric consultations, OB Laborist services, referrals to People for People, Valley Imaging Gyn Ultrasound services and Yakima Valley Radiology professional over read fees for X-Rays performed at CHCW. Medical Service items under \$20 will not be discounted. Dental Service items under \$45 will not be discounted.