COAST COMMUNITY
HEALTH
center

1010 First Street SE, Suite 110, Bandon, Oregon 97411
Phone: 541-347-2529 Fax: 541-347-9196

COAST COMMUNITY HEALTH CENTER

Sliding Fee Scale

2017 Application

Discounted Fee will not be applied to your bill until completed application & proof of income are received.

A representative from Coast Community Health Center will contact you within 10 business days after your completed application is received.

If you have questions, please call (541) 347-2529 and speak to a Patient Service Representative.

We are committed to ensuring the dignity and privacy of our patients. Coast Community Health Center provides primary health care services and may refer patients to other services as needed. The sliding scale discount applies to services offered only at Coast Community Health Center and does not include referrals to other providers.

1. Coast Community Health Center is **NOT** a free clinic. **Appointments are required**. Walk-in visits upon availability.
2. Coast Community Health Center **requires payment at time of visit**.
3. Discount will apply to services provided by Coast Community Health Center only.
4. Sliding Fee Scale rates are honored for the current calendar year. If patient's status changes, patient must reapply.
5. Patients who have qualified for state or private medical insurance since their last visit must provide this information at the time of their current visit.

HOUSEHOLD INCOME AND SIZE includes the applicant <u>and</u> anyone who the applicant can claim as a dependent or provides at least 50 % of their financial support.

Please be sure your application is <u>complete</u> and that you have included:

- ☐ Proof of income
- ☐ Signed application

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2017 Application

COAST COMMUNITY HEALTH CENTER

Sliding Scale/Discounted Program

Please complete, sign and return this form.

Name: _____ **Number: _____** **Number: _____**

(please print clearly) (HOME) (ALTERNATE)

Mailing Address: _____

_____

Number of persons living in your household: _____ Total Household Income: _____

Please list everyone in your household that you are applying for:				
Name	**DOB**	**Age**	**Monthly Income**	**Income Source**

PROOF OF HOUSEHOLD INCOME: (Sources of income for your household) Please check all that apply.

PROOF OF INCOME		**PROOF OF INCOME**	
Prior Year's Taxes		**Support from Family Member**	
Wages and Salary (or Paystubs)		**Pension Funds**	
Unemployment		**VA Benefits**	
Self-employment		**Alimony/Child Support**	
Workers' Compensation		**Scholarships/Grants**	
Public Assistance/Oregon Trail Card		**Other (specify)**	
Disability		**Migrant Worker**	

If you are unable to provide the above information, please complete the **ALTERNATIVE INCOME VERIFICATION** form on the back of this page.

Do you have health insurance? **YES** **NO** Attach copies of your card if possible.

Plan Name: _____ Member Number: _____ Annual Deductible: _____

AUTHORIZATION & RELEASE FORM

I certify that the family size and income information is correct. I understand **I must supply copies of tax returns, pay stubs, and other information** and Coast Community Health Center will verify my employment, and financial status to determine eligibility. I understand some of the information I provide is protected by Federal and/or State law, and this release allows Coast Community Health Center and its representative to verify only financial information used to determine eligibility for reduced fees for service.

I hereby release and hold harmless all individuals who provide information to verify my income. I agree to have a review of my financial status every 12 months or earlier if it improves and to pay my portion of total charges for each service, at the time of service.

_____ _____ _____

Patient Name (please print) **Signature** **Date**

OFFICE USE ONLY

Sliding Scale Rate Approved _____ **SCH Discount Approved: _____** **Approved By: _____** **Effective Date:_____**

Patient Account Number: _____ **Expiration Date: _____**

COAST COMMUNITY HEALTH CENTER
Alternative Income Verification

**** Use only if you did not fill out the household income section of the application to provide information on your income ****

Check all that apply:

- ☐ I receive SNAP benefits and can show my Oregon Trail Card.
- ☐ I receive WIC benefits and can show my WIC Card.
- ☐ I was on the Oregon Health Plan (OHP) within the last year. Verified by staff: _____
- ☐ My child is on OHP. Verified by staff: _____
- ☐ I am a teen patient seeking confidential care.
- ☐ I am homeless.
- ☐ I am not able to provide proof of my income. Please give a brief statement of why you are not able to provide proof and how you currently pay for your living expenses.

_____

_____

Self-Declare/No Income:

How are you receiving food and shelter? _____

Check all that applies to your current living situation:

- ☐ In parks/on street/under bridge
- ☐ Living in a vehicle
- ☐ Hotel/Motel
- ☐ Staying with others – not renting
- ☐ Camping/traveling with no income
- ☐ Other (explain) _____

_____ _____

Applicant's signature **Date**

CERTIFICATION BY PERSON NOT RELATED TO APPLICANT

I certify that, to the best of my knowledge and believe I know the above statements to be true. The basis of my knowledge is:

_____

_____

_____ _____ _____

Print Name Signature Date

_____ _____

Relationship to Party:

Note: It is not preferable for the person certifying the applicant's income to be an immediate family member or live in the same household. If this is the only person who can attest to the income of the applicant, their acknowledgement may be acceptable.