COAST COMMUNITY
HEALTH
center
Bandon • Port Orford

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

Sliding Fee Discount Program

2021 Application

For those eligible, we offer a Sliding Fee Discount Program that reduces fees to help you pay for services.

NEXT STEPS:

Please complete, sign and return this form. If you need help, our staff can assist you to complete the application.

You can make an appointment and receive services before your application is approved.

HAVE QUESTIONS?

Ask a Representative or call (541) 347-2529, ext. 0.

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2021 Sliding Fee Application

Eligibility for the Sliding Fee Discount Program is only based on your family size and income.

Family size is defined as a group of two or more persons related by birth, marriage, adoption, or legal partnerships (i.e. domestic partnerships) who live together; all such related persons are considered as members of one family. This includes students, regardless their residence, who are supported by their parents or others related by birth, marriage, or adoption, or legal partnerships (i.e. domestic partnerships). Self-declaration is used for family size.

Income is defined as total annual cash receipts, before taxes from all sources, including wages and salaries before any deductions, net receipts from self-employment, regular payments from social security, unemployment compensation, alimony, child support, military family allotments, pensions, and regular insurance or annuity payments, dividends, interest, net rental income. Documentation to support income are pay stubs, recent federal tax return, copy of W2 form, gross income verification completed by the employer, and/or copies of bank statements. Other documentation may be used if needed and approved by Clinic Manager, CFO, and/or CEO. If you cannot provide income information, you may self- declare your income by filling out the self-declaration form.

At the time of service, a minimum payment of $25.00 is due for all patients whose application is pending.

Name: _____ Home Phone: _____ Mobile Phone: _____
DOB: _____

Mailing Address: _____

Number of persons living in your family (as defined above): _____
Total monthly household income before taxes: _____

Please list all sources of your household/family income:

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

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I **am providing the following as proof of income. 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 or Social Security			
Self-Declaration (I am unable to provide proof of income)**			

**If you choose the self-declaration option as proof of income, you must complete the Alternative Income Verification Form. Please ask a staff member for one of these forms to complete.

Do you have health insurance? **YES** **NO** If yes, please bring your cards at every visit.

Plan Name: _____ Member ID: _____ Annual Deductible: _____
(if known)

Plan Name: _____ Member ID: _____ Annual Deductible: _____
(if known)

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AUTHORIZATION & RELEASE FORM

I certify the family size and household income information is accurate and correct to the best of my knowledge. I agree that providing incorrect or falsified or by omitting relevant information may disqualify me from the Sliding Fee Discount Program.

I understand that I can supply proof of income OR self-declare my income.

I understand that some of the information I provided is protected by Federal and/or State law, and this release allows Coast Community Health Center, and its representative, to verify only the financial information needed to determine eligibility for the Sliding Fee Discount Program.

I hereby release and hold harmless all individuals who provide information to verify my income. I agree to update my household income and family size every 12 months or whenever it changes.

In signing this form, I agree to pay my portion of the fees for each visit and that the fee may be adjusted based on my sliding fee application. I will contact Coast Community Health Center if I need to set up a payment plan.

I understand that Coast Community Health Center works with other healthcare partners who may reduce their fees for services for our eligible Sliding Fee Discount Program patients and that their sliding fee scale may differ from Coast Community Health Center's fees.

_____ _____ _____

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

OFFICE USE ONLY

Sliding Scale Rate Approved _____ **Approved By: _____** **Effective Date:_____** **Expiration Date: _____**

Patient Account Number: _____

Notes: