Community Health of Central Washington

Discounted Fee Application

Community Health of Central Washington through it clinics provides discounts medical, dental, and mental health 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: _____ 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 six 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. I will be expected to pay the associated fee at the time of each office visit once the application is approved.

_____ _____ _____

Signature of Patient / Guardian Date Financial Counselor

Disclaimer: Community Health of Central Washinton has established arrangements with Yakima Valley Memorial Hospital, Yakima Regional Medical and Cardiac Hospital, Kittitas Valley Community Hospital, Pathologh Associates, Medical Center Lab, Valley Imaging Partners and Yakima Valley Radiology to provide potiam discounted fee program to our patients at or below the federal poverty level.

Revised 2/2/2018

Community Health
of Central Washington

Discounted Fee Program

January 13, 2018 – January 15, 2019

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

	SFSD A	SFSD B		SFSD C		SFSD D		Self -Pay
# of Family Members	0	100%	100.1%	133.99%	134%	166.99%	167%	200.99%	Over 200%
1	0	$ 12,140	$ 12,141	$ 16,266	$ 16,267	$ 20,273	$ 20,274	$ 24,400	$ 24,401
2	0	$ 16,460	$ 16,461	$ 22,055	$ 22,056	$ 27,487	$ 27,488	$ 33,083	$ 33,084
3	0	$ 20,780	$ 20,781	$ 27,843	$ 27,844	$ 34,701	$ 34,702	$ 41,766	$ 41,767
4	0	$ 25,100	$ 25,101	$ 33,631	$ 33,632	$ 41,914	$ 41,915	$ 50,448	$ 50,449
5	0	$ 29,420	$ 29,421	$ 39,420	$ 39,421	$ 49,128	$ 49,129	$ 59,131	$ 59,132
6	0	$ 33,740	$ 33,741	$ 45,208	$ 45,209	$ 56,342	$ 56,343	$ 67,814	$ 67,815
7	0	$ 38,060	$ 38,061	$ 50,997	$ 50,998	$ 63,556	$ 63,557	$ 76,497	$ 76,498
8	0	$ 42,380	$ 42,381	$ 56,785	$ 56,786	$ 70,770	$ 70,771	$ 85,180	$ 85,181
9	0	$ 46,700	$ 46,701	$ 62,573	$ 62,574	$ 77,984	$ 77,985	$ 93,862	$ 93,863
10	0	$ 51,020	$ 51,021	$ 68,362	$ 68,363	$ 85,198	$ 85,199	$ 102,545	$ 102,546
11	0	$ 55,340	$ 55,341	$ 74,150	$ 74,151	$ 92,412	$ 92,413	$ 111,228	$ 111,229
12	0	$ 59,660	$ 59,661	$ 79,938	$ 79,939	$ 99,626	$ 99,627	$ 119,911	$ 119,912

Additional family members over 12 add $4320 per individual

Table showing Nominal Fee and Board of Directors approved Sliding Fee Scale Discounts

Type of Service	SFSD A	SFSD B	SFSD C	SFSD D	Self-Pay Patients
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
$20 Fee/Visit	$20 Fee/Visit	$20 Fee/Visit	$20 Fee/Visit	$20 Fee/Visit	$20 Fee/Visit

Medical Service items under $20 will not be discounted. Dental Service items under $45 will not be discounted.

Homeless persons who provide a letter from a local shelter will not be charged the nominal fee and will be considered SFSD A

Pharmacy Services: Prescription Drugs are provided at cost plus a dispensing fee for all medications. Payment in full is required at the time of dispensing.

*****Services excluded from the SFSD – Prosthetics, dentures, bleaching, cosmetic surgery, contraceptive devices, adult vaccines and services provided by other providers who are not part of CHCW.

Services discounted separately by the provider (not a CHCW provider); 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.

No patient will be denied services due to inability to pay – Please speak to a patient Financial Counselor if you have questions about your account. Financial Counselors can be reached toll free at 833-574-6100; 8:00 AM to 4:00 PM Monday – Friday; except for Holidays.