DISCOUNTED FEE PROGRAM

Everyone is welcome here. Services are available to all patients, regardless of insurance status or ability to pay. A sliding fee discount is offered to those who qualify.

The sliding fee discount is available to assist patients who do not have insurance or whose insurance does not cover enough of their medical bills. This assistance is provided through our Discounted Fee Program for qualifying patients.

QUALIFYING SERVICES

The Discounted Fee Program applies to medical visits, behavioral health services, and some medications. **Patients may be billed for devices (i.e., birth control implants) and a percentage of any procedure** that is completed at LCHC. A 25% discount will be applied if such bills are paid in full at time of payment.

If a patient has insurance, the Discounted Fee Program may assist with any procedures or treatments that are not covered by insurance as well as some medications.

PROGRAM ELIGIBILITY

To determine eligibility, a patient **must complete the Discounted Fee Program Application and provide proof of household income**. The application and proof of income will be reviewed and the patient will be notified of their eligibility. Approval for the Discounted Fee Program **may be effective for up to one year**.

If a patient does not have the required documentation for proof of income at their appointment, they **may complete a self-declaration**. If the self-declaration is reviewed and deemed eligible, the Discounted Fee Program will apply for services provided **for up to thirty (30) days**. If proof of income is not provided within those thirty (30) days, the Discounted Fee Program eligibility will expire and all services will be billed in full.

DISCOUNTED FEE PROGRAM PATIENT RIGHTS & RESPONSIBILITIES

1. **All patients may apply for the Discounted Fee Program.**
2. **Any household member over the age of 18 must provided proof of income.** Household members are people living in the same housing unit who are being supported by the same financial resources.
3. **Acceptance into the program is not guaranteed**; your application will be reviewed, and notification provided. If approved for the program, payment for services is due at the time of each visit.
4. **If a complete application accompanied by proof of income or a self-declaration are not provided before receiving care, the patient will be given fourteen calendar days to return the application and proof of income.** If not received within fourteen calendar days, the patient may be billed in full. The application will still be reviewed and considered for eligibility for discounts on future services.
5. **Patients may re-apply for the program at anytime.** If eligibility has expired, the fourteen day rule above will apply.
6. **Not all services provided at LCHC are covered under this program.** Some examples of non-covered services are:
    - External lab testing services (Interpath, CORA, Central Oregon Pathology)
    - Medical Devices (birth control implants, etc.)
7. **We may need additional information to verify your income or household size.**
8. **The guarantor of the approved application must notify LCHC of any changes to income, living arrangements, or insurance status for all household members listed on the application as soon as possible.**

PLEASE NOTE

- Do not provide original documents for proof of income; they will not be returned. You may either provide photocopies or we can make photocopies for you.
- Completion of this application is not a guarantee that you will qualify for the Discounted Fee Program.
- Any outstanding balance you owe will still be your responsibility to pay. This program only applies to charges incurred once you are approved for the program.
- You will be notified with a decision on your application within fourteen (14) calendar days.

DISCOUNTED FEE PROGRAM | ELIGIBILITY APPLICATION

Today's Date:

We encourage all applicants to meet with our Outreach team to determine whether you or any household members may qualify for the Oregon Health Plan.

Application will not be accepted unless form is complete and proof of income or self-attestation is provided.

Head of Household (Guarantor) Information

Last Name	First Name	Primary Phone	Secondary Phone

Household Information

Must be completed for all household members.

Number of Household Members:

#	Name of Household Member	Relationship	DOB	Total Gross Monthly Income	Office Use Only: MRN
1		Self			
2					
3					
4					
5					
6					

You may list additional household members to a separate sheet of paper.

Proof of Income Verification

Any item listed below may be used to verify income.

- **Pay Stubs** - minimum one month, preferably three months
  Statement from employer may be used in place of pay stubs
- **Statement from a government agency** for unemployment insurance, supplemental security income (SSI), food stamps, etc.
- **Statement of income determination** from the Department of Housing
- **Annual W-2 wage statements** from all income sources
- **Most recent tax return**
- **Pension notice**
- **Recent bank statement** from prior month showing income deposits.

If you do not have any of the documentation listed above, you may complete the self-declaration portion of this application. If approved, the Discounted Fee Program will apply to care that you and your household receive for **up to thirty (30) days**.

Self-Declaration

Must be completed if no proof of income provided.

Source(s) of Income (Name of employer(s), or other income)

Gross Monthly Earnings for Household (before taxes)

Frequency of Income Payments for Household

☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Bi-Monthly ☐ Monthly

If you have not worked or received any income from the sources listed, please explain how you have been meeting your basic living expenses.

ATTESTATION

By signing below, I attest that as of the date of my signature, the income sources listed above include all of my household income, the household members listed are all solely dependent on that income, and the self-declaration *(if provided)* is true and correct to the best of my knowledge. I also acknowledge that I have reviewed and understand the Discounted Fee Program Patient Rights and Responsibilities that were provided to me.

Applicant Signature	Date

OFFICE USE ONLY

☐ **A** - $25 Visit ☐ **B** - $30 Visit + 25% procedures done by LCHC ☐ **C** - $35 Visit + 50% procedures done by LCHC
☐ **D** - $40 Visit + 75% procedures done by LCHC ☐ **E** - 25% discount for full payment at time of services

Total Annual Earnings	Effective Dates	Employee Signature	Date
	thru		

Retroactive Dates (if applicable)	Employee Initials	Date

Notes

La Pine Community HEALTH CENTER