



N.E. Washington  
Health Programs

www.newhp.org

RENEWAL DATE \_\_\_\_\_

**Medical Clinics**

- Chewelah Community Health Center
- Kettle River Community Health Center
- Lake Spokane Community Health Center
- Loon Lake Community Health Center
- Northport Community Health Center
- Selkirk Community Health Center
- Springdale Community Health Center

**Dental Clinics**

- Colville Community Dental Clinic
- Lake Spokane Community Dental Clinic
- Springdale Community Dental Clinic

**SLIDING DISCOUNT PROGRAM**

**“WHAT IS A SLIDING DISCOUNT?”**

Sliding discount refers to a discount program that enables us to discount qualifying service charges provided at our dental and medical clinics. This sliding discount can apply to all family members and can last one year with the correct documentation, if there are no income changes within that time period.

**“HOW IS A REDUCTION IN FEE DETERMINED?”**

Sliding discount is determined based on your income level and the number of members in your household. Using this information, our staff computes the amount of sliding discount based on federal poverty guidelines. The minimum payment amount is \$20.00 for a medical office visit or \$40 for dental office visit. Depending on the level of slide qualified, this may be more.

**“HOW CAN I QUALIFY FOR A SLIDING DISCOUNT?”**

To qualify for sliding discount your income must be below 200% of the federal poverty guidelines. We will need documentation of your income and the number of members in your household.

**“WHAT TYPE OF DOCUMENTATION DO I NEED TO PROVIDE?”**

We will need verification of income. Copies of wage statements, unemployment/pay stubs, etc. may be used for income verification. A Self Declaration form may be used if these forms of verification are not available. A copy of current driver’s license or photo ID will also be asked for. This information is only used for determining your eligibility for sliding discount and is held in strict confidence.

**“WHY DO I NEED TO PROVIDE THIS DOCUMENTATION?”**

As a condition to provide the sliding discount arrangement, grantors require us to document all qualifying patients. The grantors want assurance that qualified patients are receiving health care at discounted rates.

**“WHAT HAPPENS IF I DON’T PROVIDE THE DOCUMENTATION?”**

We will accept your word of your income level and number of household members for your first visit only. . You will be asked to provide the required documents. If you need a return visit to our clinic in the future, we will require that documentation be on file to continue sliding discount. If the required documentation is not on file, you will be charged our usual charges for the services provided until verification is complete. Self-Declared income will qualify Sliding discount for 6 months. A fully verified application will qualify sliding discounts for 12 months.

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**SLIDING DISCOUNT APPLICATION**

Please complete the following information. If you are unable to answer a question, please ask the receptionist to help you. In order to determine your eligibility, complete this application and supply us with income verification. Today's services can be considered for sliding discount based on information you have written below. If, at the completion of the qualification process, you are found ineligible, you will be responsible for all charges incurred during the application process. If the information provided on this form is false or information was deliberately withheld in order to become eligible, you will be responsible for the total charges incurred—payable within 30 days.

**1. FINANCIALLY RESPONSIBLE PERSON/RESIDENCY**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SOC SEC # \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ ALTERNATIVE CONTACT PHONE # \_\_\_\_\_

**2. LIST ALL DEPENDENT MEMBERS OF HOUSEHOLD (please included yourself)**

	NAME	BIRTHDATE	SOCIAL SECURITY #	RELATIONSHIP
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____

**3. INCOME AND EMPLOYMENT**

MONTHLY INCOME \$ \_\_\_\_\_ ANNUAL INCOME \$ \_\_\_\_\_

Are you currently employed? Yes  No

Do you have other Medical Insurance? Yes  No   
(If yes please provide below)

Name of Ins. \_\_\_\_\_ Policy Id # \_\_\_\_\_

**APPLICANT'S SIGNATURE**

**DATE**

Office Use only: V or N/V Discount % \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_

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**SELF DECLARATION NOTIFICATION FOR SLIDING DISCOUNT VERIFICATION**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please state the current living situation, including the current financial status of your living situation.**

Current address / name of person you are residing with:

Financial support / tell us how you are supporting yourself:

If dependents are different from current 1040 tax return, please tell us why?

This information will be used to help us determine the level of the Sliding Discount you will qualify for if you cannot provide us with the other verification needed. This Self-declaration will expire six (6) months from the date signed below.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Other forms of verification include:**

Personal Identification – Driver’s License, ID Card

Proof of all current income – pay stubs, SS information, bank statements, 1040 tax return



**ADDITIONAL INFO:**

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**OFFICE USE ONLY**

**VERIFICATION GIVEN BY PATIENT**

- Pay Stub—Unemployment
- Tax Form 1040 P. 1
- W-2's
- 1099's (Pension)
- Bank Statement / Loan Application
- Social Security Benefit Statement
- PHOTO ID

Other: \_\_\_\_\_

Sliding Discount Classification Percent: \_\_\_\_\_ %

Application is:                      Rejected                       Accepted

Reason Rejected:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**AUTHORIZED BY**

\_\_\_\_\_  
**DATE**