



NORTHWEST HEALTH SERVICES

**YOUR COMMUNITY HEALTH CENTER WELCOMES YOU TO OUR
SLIDING FEE DISCOUNT PROGRAM**

**SLIDING FEE APPLICATIONS ARE AVAILABLE AT ALL NORTHWEST HEALTH SERVICES
LOCATIONS:**

BRAYMER CLINIC	660-645-2218
CAINSVILLE MEDICAL CLINIC	660-893-5753
KING CITY	660-535-4347
MOUND CITY	660-442-5464
OREGON	660-446-3307

HAMILTON:

HAMILTON MEDICAL CLINIC	816-583-2151
HAMILTON PHARMACY SERVICES	816-583-2881

SAINT JOSEPH:

FAMILY MEDICINE ASSOCIATES	816-232-6818
NORTH END HEALTH CENTER	816-233-3338
NORTHWEST BEHAVIORAL HEALTH	816-232-4417
NORTHWEST FAMILY DENTAL	816-364-6444
NHS @ FAMILY GUIDANCE CENTER	816-901-1082
SOUTH SIDE HEALTH CENTER	816-238-7788
RAISE CLINIC	816-233-3699
HOME UNIT	816-233-5188

SAVANNAH:

SAVANNAH MEDICAL CLINIC	816-324-3121
NORTHWEST DENTAL SERVICES	816-324-5644

**QUESTIONS? PLEASE ASK! STAFF AT ANY LOCATION CAN ASSIST YOU, OR
CALL OUR SLIDING FEE SPECIALIST AT 816-271-8248**



NORTHWEST HEALTH SERVICES

SLIDING FEE PROGRAM DETAILS - 2009

Northwest Health Services fees are based on a sliding fee scale. The Sliding Fee Scale is a “discount” program which includes medical, dental, behavioral health and pharmacy services and is made possible through grant funding.

To determine if you and your family qualify for the Sliding Fee Program, we need to ask you to bring in personal financial information. Any information we ask you for will be strictly confidential. **None of your personal information, financial or medical, can be released without your written permission.**

Sliding Fee is based on total **household size** and **household income**. Sliding fee applications are effective from **May 1 thru April 30th** of each calendar year. As of May 1st of each calendar year, all sliding fee will expire until a new application is completed and approved.

HOUSEHOLD SIZE:

- **Household size includes all people living in your home if you are financially responsible for them.**
- **Marital status is not a factor when determining household size.**
- **Household income includes all income for all people that make up your household size.**
- **If someone shares your home, but is not your financial responsibility, they cannot be counted in your household size.**
 - **They can apply for Sliding Fee based on their income and the number of household members they are financially responsible for.**

HOUSEHOLD INCOME:

In addition to income from jobs, also included is alimony, child support, Social Security Income, Pensions, Unemployment, etc. The Sliding Fee Program requires proof of **all** income. When you bring in the required income information, we will photocopy it and return all originals to you. Following is a partial list of acceptable forms of proof of income.

- **Prior year’s tax return (This is the preferred form of proof of income, if it accurately reflects your current household income.)**
- **W-2 or 1099 from prior year**
- **Paycheck stubs**
- **Letter from employer showing YTD wages and dates of employment**
- **Letter from Social Security, VA, Employment Office, etc.**
- **Other proof of income may be accepted and will be determined on an individual basis.**



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SLIDING FEE COPAYS:

Medical and Behavioral Health:

- **Patients under 19 years of age, RAISE Clinic and HOME Unit patients (regardless of age) whose household income level is below 100% will not be required to pay a copay.**
- **All other sliding fee patients will pay a copay. When your sliding fee application has been approved, you will be informed of your copay amount.**
- **Copays must be paid at the time of service.**

Dental:

- **“Basic” dental care requires a copay similar to the copay for medical office visits.**
- **Payment for dental “procedures” vary based on the type of procedure.**
- **If dental procedures are required, the amount you are responsible for will be discussed with you prior to dental services being rendered.**

Pharmacy:

- **Copays for prescriptions will vary since they are based on “cost”.**
- **All prescriptions must be paid for when they are picked up.**

SLIDING FEE AND INSURANCE COVERAGE:

The purpose of the sliding fee program is to make sure that the “under insured” as well as the “un-insured” have access to healthcare. If you have health insurance, but also qualify for Sliding Fee:

- **You will need to bring your insurance card with you to each visit.**
- **You will need to pay your copay at the time of service.**
- **NHS will file your claim with the insurance company.**
- **After your claim has been processed and/or paid, you will be given the sliding fee discount you are eligible for.**
- **If you receive an insurance payment, you will need to bring it to the clinic before you will be given a discount for the visit.**



NORTHWEST HEALTH SERVICES

HOSPITAL CARE:

If you are an existing NHS patient, are currently eligible for Sliding Fee, and are admitted to the hospital by a Northwest Health Services physician the following PHYSICIAN services are Sliding Fee eligible.

- Hospital admission
- Hospital follow up visits
- Hospital discharge

HOSPITAL CARE NOT ELIGIBLE FOR SLIDING FEE:

- Surgeries and other procedures performed while you are in the hospital.

OTHER SERVICES NOT ELIGIBLE FOR SLIDING FEE:

- Services related to motor vehicle accident
- Work Comp services; other work related services
- Lab/x-ray ordered by providers outside NHS
- Elective/cosmetic procedures
 - ✓ Circumcision
 - ✓ Removal of moles/skin tags, etc. for cosmetic reasons
 - ✓ Certain dental procedures

ADDITIONAL SLIDING FEE INFORMATION:

- Patients under 19 years of age must have a Medicaid denial letter to be eligible for Sliding Fee.
- If your household income or family size changes throughout the year, it is your responsibility to inform NHS staff at the time of your next appointment.
- Sliding Fee applications must be completed, signed and approved prior to services being provided.
- Sliding Fee is not retro-active. Sliding Fee discounts cannot be applied to prior dates of service.
- Partially completed Sliding Fee applications cannot be accepted.
- Sliding Fee applications without proper proof of income cannot be accepted.

Northwest Health Services is pleased to help meet your healthcare needs. We invite you to share this Sliding Fee information with others. If you have questions about this program, please talk to the staff at any Northwest Health Services clinic or call our Sliding Fee Specialist at 816-271-8248.

TODAY'S DATE:



NORTHWEST HEALTH SERVICES

Applicant Name:

Guarantor # (Office use only)

Address:

City, State, Zip:

County:

Social Security #:

____ - ____ - _____

Date of Birth :

Sliding Fee Application:

It is necessary to ask you for personal financial information in order to give you a discount on your medical services. This information will be held in our office in strict confidence. Sliding Fee applications expire on **May 1** of each calendar year. At that time, we will ask you to again verify your current income and number of household members in order to receive discounts on your medical services.

HOUSEHOLD INCOME:

Household income includes ALL income generated by the household, regardless of marital status. Income may include but is not limited to the following:

- | | | |
|-------------------------|-----------------|-----------------|
| Salaries | Alimony | Social Security |
| Student Pell Grants | Interest Income | |
| Pensions | Child Support | Disability |
| Self Employment Records | Unemployment | |

Please circle all of the above that apply to your household income and provide proof of all income circled above.

My yearly household income is :
\$_____.

HOUSEHOLD MEMBERS:

Household members must actually live in your household, regardless of marital status, and you must be financially responsible for them. I am financially responsible for (#)_____ household members (include yourself).

(All household member's names, date of birth and SS# must be listed on next page.)

- I understand :**
- **If I have insurance I must show a copy of my current insurance card at each visit and my insurance must be filed and processed/paid before I receive Sliding Fee discounts.**
 - **If I receive insurance payments I must bring the payment to the office to be applied to my visit before my Sliding Fee discount will be given.**
 - **Services not eligible for discount are:**
 - **Motor Vehicle Accidents**
 - **Workers Comp**
 - **Elective procedures and hospital procedures**
 - **Services received from providers outside Northwest Health Services**



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HOUSEHOLD MEMBERS:

	Name	Relationship	Date of Birth	Social Security #
1				____ - ____ - ____
2				____ - ____ - ____
3				____ - ____ - ____
4				____ - ____ - ____
5				____ - ____ - ____
6				____ - ____ - ____
7				____ - ____ - ____
8				____ - ____ - ____

- I have read and understand the information contained in "Sliding Fee Program Details " and agree to abide by these guidelines.
- I understand my information will be kept in strict confidence and that if my income changes I am required to notify NHS on my next visit to the clinic.
- I declare the information I have given is true and give Northwest Health Services (NHS) consent to investigate any information given in this application.
- Based on the number of people in my household and the income information I provided, I understand my copay for each medical visit is \$_____ and this copay must be paid at the time of service.
- I further understand that copays for dental services vary, based on procedure, and the amount due from me will be discussed with me prior to services being rendered.

Applicant Signature:	Date:	
<i>(FOR OFFICE USE ONLY)</i> PAA Signature:	Date:	INCOME LEVEL
SFS Specialist Verification/Signature:	Date:	INCOME LEVEL



Per patient disclosure, _____ is not employed and has had no income this year.

Patient Signature

Date

NHS Staff Signature

Date

I verify that _____ is currently unemployed and has had no income this year. I help provide for his/her living expenses, however I am not responsible for his/her debts.

Signature

Date

Relationship

Patient/Guardian Signature

Date

NORTHWEST HEALTH SERVICES, INC.

SLIDING FEE DISCOUNT TABLE 2009 – MEDICAL & BEHAVIORAL HEALTH

	<100% of Poverty Level		100-150% of Poverty Level	151-200% of Poverty Level	>200%
	<i>Adults: Copay \$25 (Below 19 yr/Copay\$0)</i>		<i>Copay \$35.00</i>	<i>Copay \$45.00</i>	<i>Patient Pays 100%</i>
POVERTY LEVEL	Family Size	SF Plan A	SF Plan B	SF Plan C	
10,830	1	0 to 10,830	10,831 16,245	16,246 21,660	Over 21,661
14,570	2	0 to 14,570	14,571 21,855	21,856 29,140	Over 29,141
18,310	3	0 to 18,310	18,311 27,465	27,466 36,620	Over 36,621
22,050	4	0 to 22,050	22,051 33,075	33,076 44,100	Over 44,101
25,790	5	0 to 25,790	25,791 38,685	38,686 51,580	Over 51,581
29,530	6	0 to 29,530	29,531 44,295	44,296 59,060	Over 59,061
33,270	7	0 to 33,270	33,271 49,905	49,906 66,540	Over 66,541
37,010	8 *	0 to 37,010	37,011 55,515	55,516 74,020	Over 74,021

* For family units with more than 8 members, add \$3,740 for each additional member.

Discounted fees are contingent upon **proof of income** and cannot be authorized without such proof. Completed income tax returns are the **preferred** acceptable proof of income. Any **variances** from this policy must be approved by the Sliding Fee Specialist in advance.

NORTHWEST HEALTH SERVICES, INC.

**SLIDING FEE DISCOUNT TABLE 2009 –
PHARMACY**

	<100-200% of Poverty Level		>200% of Poverty Level
	<i>Cost + \$11.00 Dispensing Fee</i>		<i>Patient Pays 100%</i>
POVERTY LEVEL	Family Size	SFS A, B, C	
10,830	1	0 to 21,660	Over 21,661
14,570	2	0 to 29,140	Over 29,141
18,310	3	0 to 36,620	Over 36,621
22,050	4	0 to 44,100	Over 44,101
25,790	5	0 to 51,580	Over 51,581
29,530	6	0 to 59,060	Over 59,061
33,270	7	0 to 66,540	Over 66,541
37,010	8 *	0 to 74,020	Over 74,021

For family units with more than 8 members, add \$3,740 for each additional member.

Discounted fees are contingent upon **proof of income** and cannot be authorized without such proof.
Completed income tax returns are the **preferred** acceptable proof of income.
Any **variances** from this policy must be approved by the Sliding Fee Specialist in advance.

SLIDING FEE PATIENTS PAY:

Prescription Cost + \$11 Dispensing Fee Only

Effective May 1, 2009
Northwest Health Services, Inc.

NORTHWEST HEALTH SERVICES, INC.

SLIDING FEE DISCOUNT TABLE 2009 – DENTAL

	<100% of Poverty Level		100-150% of Poverty Level	151-200% of Poverty Level	>200%
	<i>(Below 19 yr/Copay\$0) SEE ATTACHED FEE SCHEDULE FOR COPAY</i>		<i>SEE ATTACHED FEE SCHEDULE FOR COPAY</i>	<i>SEE ATTACHED FEE SCHEDULE FOR COPAY</i>	<i>Patient Pays 100%</i>
POVERTY LEVEL	Family Size	SFS A	SFS B	SFS C	
10,830	1	0 to 10, 830	10,831 16,245	16,246 21,660	Over 21,661
14,570	2	0 to 14,570	14,571 21,855	21,856 29,140	Over 29,141
18,310	3	0 to 18,310	18,311 27,465	27,466 36,620	Over 36,621
22,050	4	0 to 22,050	22,051 33,075	33,076 44,100	Over 44,101
25,790	5	0 to 25,790	25,791 38,685	38,686 51,580	Over 51,581
29,530	6	0 to 29,530	29,531 44,295	44,296 59,060	Over 59,061
33,270	7	0 to 33,270	33,271 49,905	49,906 66,540	Over 66,541
37,010	8 *	0 to 37,010	37,011 55,515	55,516 74,020	Over 74,021

* For family units with more than 8 members, add \$3,740 for each additional member.

RAISE Clinic patients are eligible to receive dental services up to \$1,000 per year without copay. After reaching services that total \$1,000 RAISE Clinic patients who choose to continue to receive dental services, will be expected to pay applicable copay at the time of service.

Copay does not apply for **HOME Unit patients** who are **100% of poverty or below** for dental services provided at **HOME Unit**.

Discounted fees are contingent upon **proof of income** and cannot be authorized without such proof. Completed income tax returns are the **preferred** acceptable proof of income. Any **variances** from this policy must be approved by the Sliding Fee Specialist in advance.

SLIDING FEE DISCOUNT TABLE 2009 – DENTAL

COPAY AMOUNTS FOR BASIC DENTAL SERVICES ARE AS FOLLOWS:

SFS A = \$20

SFS B = \$30

SFS C = \$40

BASIC SERVICES INCLUDE:

Diagnostic Exams X-rays Cleaning	\$20, \$30 or \$40 Copay
+	+
Filling; Tooth Removal	Copay applies for each tooth treated

COPAY AMOUNTS FOR DENTURES:

\$400 - \$600 each upper and lower denture

Emergency Dental Services:	
NHS patients with current Sliding Fee Scale status:	
Emergency Diagnostic Exam (Includes X-ray)	Copay \$20, \$30 or \$40
+	+
Copay for treatment of each tooth.	Extraction copay \$40 per tooth
Patients who do not have a current Sliding Fee Scale status will be charged according to the fee schedule:	
Emergency Diagnostic Exam	\$48 (Includes X-ray)
+	+
Cost of treatment per tooth.	(Extractions \$107 Per tooth.)

Other dental services are also available. Your Dentist will discuss the cost of each procedure with you prior to services being provided.