Mattawa Community Medical Clinic

Sliding Fee Program

As a Federally Qualified Healthcare Clinic, Mattawa Community Medical Clinic can offer most services on a sliding fee schedule. This means that depending on your household income and family size, you may be eligible for reduce discounts.

Sliding Fee Program Eligibility:

Mattawa Community Medical Clinic staff is available to assist patients in determining their eligibility for discounts through the Sliding Fee Program. Mattawa Community Medical Clinic uses the current Federal Poverty Guidelines to determine the discount available. You will find a schedule and application attached.

How to apply for the Sliding Fee Program:

Please complete the attached application and return it to the Mattawa Community Medical Clinic accounts representative or navigator. Eligibility will be based on subsequent review of the application and additional relevant materials. You will be contacted with a determination.

If you have questions about the Sliding Fee Program at Mattawa Community Medical Clinic, please call our business office at (509) 932-4499

Note: YOU CAN APPLY FOR MEDICAL BENEFITS THROUGH THE WASHINGTON HEALTHCARE BENEFITS EXCHANGE ONLINE AT http://www.wahbexchange.org/ OR BY CONTACTING OUR PATIENT NAVIGATOR AT (509) 932-4499

Mattawa Community Medical Clinic

Sliding Fee Program Application

Head of Household: _____Date of Birth: _____/ _____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: (_____) _____- _____ [ ] Home [ ] Cell [ ] Message phone

Dependent Family Members:

Please list all household members residing at the above address with their date of birth respectively. Indicate if members are employed and/or have income.

Income?

1. _____ Relationship: _____ DOB: _____/_____/_____ Y / N
2. _____ Relationship: _____ DOB: _____/_____/_____ Y / N
3. _____ Relationship: _____ DOB: _____/_____/_____ Y / N
4. _____ Relationship: _____ DOB: _____/_____/_____ Y / N
5. _____ Relationship: _____ DOB: _____/_____/_____ Y / N
6. _____ Relationship: _____ DOB: _____/_____/_____ Y / N
7. _____ Relationship: _____ DOB: _____/_____/_____ Y / N
8. _____ Relationship: _____ DOB: _____/_____/_____ Y / N
9. _____ Relationship: _____ DOB: _____/_____/_____ Y / N
10. _____ Relationship: _____ DOB: _____/_____/_____ Y / N

Mattawa Community Medical Clinic

You are required to provide proof of listed income in order to complete your application. The following are acceptable forms of income. Please indicate attached, not applicable, or reason unable to provide.

Proof of Income for each household member:

- Current pay stubs (2-months' worth) within the last 3-month period prior to application.
  [ ] Attached [ ] Not applicable
  Unable to provide because: _____

- Current W-2 forms
  [ ] Attached [ ] Not applicable
  Unable to provide because: _____

- Current Federal Income Tax (1040-1040EZ Form)
  [ ] Attached [ ] Not applicable
  Unable to provide because: _____

- Letters approving /denying unemployment compensation.
  [ ] Attached [ ] Not applicable
  Unable to provide because: _____

- Proof of Social Security Benefits and/or Pension payments, if applicable.
  [ ] Attached [ ] Not applicable
  Unable to provide because: _____

- Do you have any other sources of income? Yes _____ No _____

If yes, please explain: _____
_____

THE APPLICANT FOR THE SLIDING FEE PROGRAM, AFFIRM THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AGREE TO PROVIDE ANY ADDITIONAL INFORMATION AS REQUESTED IN ORDER TO DETERMINE ELIGIBILITY.

Signature: _____ Date: _____/_____/_____

IF YOU HAVE ANY QUESTIONS CONCERNING THIS APPLICATION, PLEASE DIRECT YOUR QUESTIONS TO THE PATIENT ACCOUNTS REPRESENTATIVE AT **509-932-4499**

Received date: _____ Account # _____

Mattawa Community Medical Clinic

Please do not write below this line (for MCMC Office use Only)

Document was received on: _____

Information verified by: _____

Annual Income: _____

Total Household Members: _____

Date Range: _____

Federal Poverty Guideline Level: _____ Patient Slide/Percent due: _____ %

Reviewed by Signature: _____ Date: _____

Approved Signature: _____ Date: _____

Patient Notified: _____ Letter Sent: _____ Other: _____

Notes_____

_____

Received date: _____ Account # _____

Mattawa Community Medical Clinic

Special Circumstances Exception Letter

Patient name _____ Date _____

Account number _____

Please explain if you have special circumstances that are interfering with your ability to pay your Sliding fee balance that should be considered:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature _____ Date _____

Please do not write below this line (for MCMC Office use Only)

Current balance: _____ Additional notes: _____

Reduction: Denied [ ] Approved [ ] _____ % write off of current balance

Approval Signature _____ Date _____

Mattawa Community Medical Clinic

Self-Declaration of Income-Attestation letter

Patient name _____ Date _____

Account number _____

Please explain why you are unable to provide proof of income for the Sliding Fee program application:

_____

_____

_____

_____

_____

_____

Please provide contact information of a person with whom we can verify the above statement:

Name _____ Relationship _____

Address _____ Phone #_____

City ST ZIP _____

_____

Applicant Signature _____ Date _____

Please do not write below this line (for MCMC Office use Only)

Status: Approve [ ] Denied [ ]

Approval Signature _____ Date _____