DESCHUTES RIM
HEALTH CLINIC

1605 George Jackson Rd, Maupin, OR 97037

Phone: 541-395-2911 Fax: 541-395-2912

Sliding Fee Discount Program

2024 Application

For those eligible, we offer a Sliding Fee Discount Program that reduces fees to help you pay for services.

Next Steps:

Please complete, sign and return this form within 30 days of your visit. If you need help, our staff can assist you to complete the application.

You can make an appointment and receive services before your application is approved with a $75 deposit.

Have Questions?

Call the clinic at 541-395-2911

2024 Sliding Fee Application

Discounted Services

The patient/guarantor is responsible for paying their portion of the fees for each medical or dental visit.

For medical services, the Sliding Fee Discount only applies to the **office visit**; additional services, such as blood work, urinalysis, suture placement/removal, minor procedures, strep tests, COVID tests, vaccinations, drug tests, injections, lavages, etc. are not covered by the program and the patient/guarantor will be financially responsible for the full cost of the additional services*.

For dental services, the Sliding Fee Discount only applies to the **office visit (oral exam) and x-rays**; additional services, such as cleanings (prophylaxis), fillings, application of fluoride, sealants, crowns, dentures, extractions, etc. are not covered by the program and the patient/guarantor will be financially responsible for the full cost of the additional services*.

*A 10% discount is offered on the cost of the additional services if the amount is paid in full within 30 days of the first statement. The 10% discount does not apply to the sliding fee for the office visit/x-rays. Please contact the clinic if the balance cannot be paid in full within 30 days and a payment plan is needed.

Definitions

Eligibility for the Sliding Fee Discount Program is only based on your family size and income.

Family size is defined as a group of two or more people related by birth, marriage, adoption, or legal partnerships (i.e. domestic partnerships) who live together; all such related persons are considered as members of one family. This includes students, regardless of their residence, who are supported by their parents or others related by birth, marriage, or adoption, or legal partnerships. Self-declaration is used for family size.

Income is defined as total annual cash receipts, before taxes from all sources, including wages and salaries before any deductions, net receipts from self-employment, regular payments from social security, unemployment compensation, alimony, child support, military family allotments, pensions, and regular insurance or annuity payments, dividends, interest, net rental income. Documentation to support income are pay stubs, recent federal tax return, copy of W2 form, gross income verification completed by the employer, and/or copies of bank statements. Other documentation may be used if needed and approved by Clinic Manager, CFO, or Administrative Assistant.

Application

Do you have health insurance? **YES** **NO**

Plan Name: _____ Member ID: _____

Plan Name: _____ Member ID: _____

Patient Name: _____

Guarantor Name (if different than Patient): _____

Phone: _____ Alternate Phone: _____

Mailing Address: _____

Number of persons living in your family (as defined above): _____

Total monthly household income before taxes:_____

Please list all sources of your household/family income:

Who's Income?	Monthly Gross Income	Income Source

I am providing the following as proof of income. Please check all that apply.

PROOF OF INCOME	CHECK IF YES	PROOF OF INCOME	CHECK IF YES
Prior Year's Taxes		Support from another Family Member	
Wages and Salary (or Paystubs)		Pension Funds	
Unemployment		VA Benefits	
Self-Employment		Alimony/Child Support	
Worker's Compensation		Scholarships/Grants	
Public Assistance/Oregon Trail Card		Other (Specify)	
Disability or Social Security			

If you do not have any source of income, please explain how your monthly living expenses are covered (rent/mortgage, food, gas, utilities, etc.):

Authorization and Release Form

I certify the family size and household income information is accurate and correct to the best of my knowledge. I agree that providing incorrect or falsified or omitting relevant information may disqualify me from the Sliding Fee Discount Program.

I understand that I can supply proof of income OR self-declare my income; self-declaration will be approved at 200% FPL and only with a declaration signed by whomever is paying all my housing expenses.

I understand that some of the information I provide is protected by Federal and/or State law, and this release allows White River Health District, and its representative, to verify only the financial information needed to determine eligibility for the Sliding Fee Discount Program.

I hereby release and hold harmless all individuals who provide information to verify my income. I agree to update my household income and family size every 6 months or whenever it changes.

In signing this form, I agree to pay my portion of the fees for each visit and that the fee may be adjusted based on my sliding fee application.

I understand that White River Health District works with other healthcare partners who may reduce their fees for services for our eligible Sliding Fee Discount Program patients and that their sliding fee scale my differ from White River Health District's fees.

_____	_____	_____
Patient/Guarantor Name (Print)	Signature	Date

If self-declaring income without providing proof of income: The person below acknowledges that they are fully financially responsible for the housing expenses of the above patient.

_____	_____	_____
Responsible Party for expenses (print)	Signature	Date

OFFICE USE ONLY	
Sliding Scale Rate:	Approved By:
Effective Date:	Expiration Date:
Notes:	

FPL Guidelines with Sliding Fee Schedule

Household/ Family Size	2024 Federal Poverty Level for the 48 Contiguous States (Annual Income)				
	100%	133%	138%	150%	200%
	No Fee	**$35**	**$35**	**$45**	**$55**
1	$15,060	$20,030	$20,783	$22,590	$30,120
2	$20,440	$27,185	$28,207	$30,660	$40,880
3	$25,820	$34,341	$35,632	$38,730	$51,640
4	$31,200	$41,496	$43,056	$46,800	$62,400
5	$36,580	$48,651	$50,480	$54,870	$73,160
6	$41,960	$55,807	$57,905	$62,940	$83,920
7	$47,340	$62,962	$65,329	$71,010	$94,680
8	$52,720	$70,118	$72,754	$79,080	$105,440
Each person over 8, add	$5,380	$7,155.40	$7,424.40	$8,070	$10,760

Household/ Family Size	2024 Federal Poverty Level for the 48 Contiguous States (Monthly Income)				
	100%	133%	138%	150%	200%
	No Fee	**$35**	**$35**	**$45**	**$55**
1	$1,255	$1,669	$1,732	$1,883	$2,510
2	$1,703	$2,265	$2,351	$2,555	$3,407
3	$2,152	$2,862	$2,969	$3,228	$4,303
4	$2,600	$3,458	$3,588	$3,900	$5,200
5	$3,048	$4,054	$4,207	$4,573	$6,097
6	$3,497	$4,651	$4,825	$5,245	$6,993
7	$3,945	$5,247	$5,444	$5,918	$7,890
8	$4,393	$5,843	$6,063	$6,590	$8,787
Each person over 8, add	$448.33	$596.28	$618.70	$672.50	$896.67