



For Clinic Use
Date Received: _____
Received by: _____
Patient # _____

Sliding Discount Fee Schedule Application

It is the policy of Cow Creek Health and Wellness Center (CCH&WC) to provide patient-centered primary care, regardless of the patient's ability to pay. Discounts are offered based upon household income and the number of persons living in the household. A sliding fee schedule is used to calculate the basic discount and is updated each year using federal poverty guidelines. Once approved, and based on your source of income, the discount will be honored for up to one year from the date of application, after which the patient must reapply.

A completed application (including verification of income) must be on file and approved by CCH&WC before a discount will be applied. If the applicant is eligible for other assistance programs, such as the Oregon Health Plan, CCH&WC staff is available to assist the applicant with applying for these programs in addition to the Sliding Discount Fee Schedule offered by CCH&WC.

Patient Information

Name: _____
Last First MI

Address: _____
Street City State Zip Code

Date of Birth: _____ **Primary Care Physician:** _____

Guarantor Information

Name: _____
Last First MI

Address: _____
Street City State Zip Code

Phone Number: _____ **Date of Birth:** _____
Home/Cell Work

Required Documentation

Please check that you have attached the following documentation. Cow Creek Health and Wellness Center CANNOT, by federal statute, provide you with a discount without proof of qualifying income.

- Copy of previous year's tax return
- Copy of paystubs showing income YTD
- SNAP or TANF eligibility letter* (If applicable)
- Other

FOR OFFICE USE ONLY	Sliding Discount Rate: A B C D
	Self-Declared: _____ Applied for OHP Yes No Date: _____
	Application Date: _____ Expiration Date: _____
	Total Mo. Income: _____ Number of Household Members: _____
	Staff member completing form: _____ Date: _____



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Household Size Information

List ALL individuals living in the household. If you need more room, please attach an additional sheet.

Name/Relationship	DoB	Age	Name/Relationship	DoB	Age
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Household Earnings Information

Please indicate ALL people living in your household who contribute financially, including applicant.

Include anyone at least 18 years of age or older who reside in the household and contribute to the basic living expenses of the household (including yourself). Income includes gross (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, pensions, and/or IRA distribution income or other retirement income, etc.

Household Members	Age	Source of Income or Employer	Monthly Gross Income
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

To the best of my knowledge, the above information is accurate and complete for all members of my household.

Printed name of patient or patient's legal representative

Relationship to patient

Signature of patient or legal representative

Date

This application process was discussed with the patient by:

Staff Name

Staff Signature

Date



Sliding Fee Scale Application - Proof of Income Checklist

Cow Creek Health & Wellness Center (CCH&WC;) offers a sliding fee discount program to help make healthcare affordable. If you've been denied Medicaid or other medical assistance, you may still qualify for reduced fees based on your household income and size. All information you share is confidential and used only to determine eligibility for this program.

Step 1: Provide Proof of Income for Each Earner

- Recent pay stubs (last 1-3 months)
- W-2 form (most recent tax year)
- Federal income tax return (Form 1040 or 1040EZ)
- Unemployment benefit statement
- Social Security award letter (SSA or SSI)
- Disability benefit letter
- Pension or retirement statement
- Child support or alimony statement
- Self-employment records (profit/loss statement, 1099 forms, or business ledger)

Step 2: Alternative Proof (if you don't have the above)

- Employer letter verifying wages/hours
- Bank statements showing regular income deposits
- Tribal per capita payment statement
- Rental income receipts or lease agreements
- Signed Zero Income Statement (available from the clinic)

Step 3: Proof of Household Size (if requested)

- Birth certificates or tribal enrollment cards for dependents
- Marriage certificate / domestic partnership proof
- Guardianship or custody papers
- School enrollment records for children

Special Situations

- College student – financial aid award letter or proof of no income
- Seasonal worker – year-to-date income summary or last year's tax return
- Homeless / no fixed address – letter from shelter, case manager, or social service provider

Patient Name: _____

Date Submitted: _____

Reviewed By: _____