



# NORTHEAST MISSOURI HEALTH COUNCIL

*Partners for a Lifetime of health*

## **Northeast Missouri Health Council, Inc. SLIDING FEE SCALE REQUIREMENTS**

Northeast Missouri Health Council offers a need-based sliding fee scale to help make healthcare costs more affordable for qualifying patients. The sliding scale is based on family size and income level up to 200% of the current Health and Human Services Poverty Guidelines.

### **APPLICATION FORM**

**Applicant Names**

**Date of Birth**

**Total Income** from 1040 Tax Return and Income for all individuals

### **PROOF OF INCOME FOR THE HOUSEHOLD**

**required when an income tax return has been filed**

a) IRS 1040 Income Tax Form

- Dependents listed on IRS 1040 ages 18 and over must provide one of the following:
  - Two letters of unemployment if not working
  - IRS 1040
  - Copy of pay stubs for prior month
  - W-2

**Required when an income tax return has not been filed**

One (1) of the following acceptable proofs of income

- **Copy of most current W-2** - use Box 1 as Gross Income
- **Copy of pay stubs** for all incomes for 1 month (a minimum of 2 stubs if paid monthly)
- **Self-employed individuals** must provide accounting of income or quarterly tax payments
- **Social Security** will **NOT** be counted as household income for purposes of determining slide eligibility and category.
- **Two letters (2)** from non-family members confirming that the patient has no income. The letter should include printed name, signature and date.

- Discounts will be applied **ONLY** 30 days prior to the completion of the application.
- The slide information covers the current fiscal year (April through March), and only individuals listed on the application are covered.
- Slide category is based only on the number of qualified individuals and income verification.
- **Your copay is due at the time of service.**

Please contact the NMHC Billing office at 660-627-5757 if you have any questions.

**SERVICES CANNOT BE DISCOUNTED UNTIL THE APPLICATION AND CONFIRMATION  
OF INCOME ARE COMPLETED.**

**Northeast Missouri Health Council  
Application for Sliding Fee Scale Discount**

**Due Back Approx**  
/ /

The Northeast Missouri Health Council, Inc. may be able to offer services at a discounted price based on the number of members in your household and your combined income. If you wish to determine the amount of discount available to you, the following information is required. Information reported should be as accurate and complete as possible and will be kept completely confidential.

*HOH	Entered in chart UDS tab	Last Name	First Name	DOB	Age	Relationship to applicant
						<i>Self</i>

**Your discount will apply to all our clinics, but not all services are covered by the sliding fee program.** Please inquire before services are provided if you need to be informed of covered services.

If you have insurance, your signature on this form is our release to file your insurance for the full amount of services provided. The clinic is entitled to recover the full amount charged from insurance and will slide off the balance only after all insurance payments or denials have been received.

**If proof of income is not received and the slide application is not completed within 30 days of services, the patient must pay the full charge.** The application qualifies the individuals listed above for the slide category determined for the entire current fiscal year based on the date the application is completed. Our fiscal year is from April 1 through March 31 and a new application must be completed every fiscal year.

I have read and understand all of the information. All information recorded is correct, truthful and complete. If there is a change in the number of applicants or my financial situation, I will contact the clinic immediately and re-apply if necessary.

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Applicant Signature** \_\_\_\_\_

**BELOW THIS LINE IS FOR OFFICE USE ONLY**

\*\*\*\*\*

Proof of Income Documents	Date received
<b>If patient filed a recent Tax Return</b>	
(1) Most Recent Income Tax Return for confirmation of Adjusted Gross Income	
<b>If patient did not file tax return, ONE of the following must be provided</b>	
(1) Copy of most current W-2 (use figure in Box 1 for total patient income)	
(2) Copy of pay stubs (for all incomes for a minimum of 1 month)	
(3) Self-employed individuals must provide some accounting of income or quarterly tax payments	
(4) Two (2) letters from non-family confirming the patient has no income	

**Total number of applicants:** \_\_\_\_\_ **Annual verified income:** \$ \_\_\_\_\_

**Slide Category:** \_\_\_\_\_ **Completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(staff signature)