Community Health
of Central Washington

2024 Discounted Fee Application

Community Health of Central Washington through its clinics provides discounts medical, dental, and mental health services for families at or below 200% of the federal poverty level. If you think you may qualify, fill out the application completely and provide all the necessary documentation described below.

Patient Name: _____ Phone Number: _____ Birth Date: _____

Household Income: Includes the total compensation, welfare, disability, and other payments received from all members within the household.

Total household income: $_____

Family Size: List the names of each family member living within your household.

Family Member Name	*Relationship*	*Birth date*

Total Family Size: _____ ***If more than six list on back***

Verification: Please provide the following documents:

- Previous year's income tax return
- Pay stub from the **most recent 3 months** from each member of the household.
- Any paperwork previously verified from the State, Federal Government, or liable public source:
  - State / Federal application of Aid (Medicaid, food stamps, etc.)
  - Unemployment or disability benefits
  - Social Security income letter for current year
  - Unhoused people, a letter from a shelter, church, physician, or other public source verification.
  - Other (i.e. Student's grant information, etc.)
- Letter from employer verifying income with employer's contact information.
- Letter from Court showing child support or alimony or other payments

☐ I prefer to **not** state my family's size and annual income. ***I understand that I am responsible for the full charge for all services rendered at the clinics of Community Health of Central Washington; and that I must pay for the services on the day I receive them.***

☐ I attest that the information provided above is true and correct. I understand that all discounts are contingent upon verification of required documentation. I further understand that if I do not provide necessary documentation at the time of service, I have 30 business days from the date of this application to provide supporting documents. Otherwise, I will be expected to pay the full amount for services at the time they are rendered. I will be expected to pay the associated fee at the time of each office visit once the application is approved.

_____ _____ _____

Signature of Patient / Guardian Date Signature of **PFC** Proscessing Application

Disclaimer: Community Health of Central Washington has established arrangements with MultiCare Yakima Memorial Hospital, Kittitas Valley Community Hospital, PathologyQuest Diagnostics lab, ; Valley Imaging Partners and Yakima Valley Radiology to provide patient discounted fee program to our patients at or below the federal poverty level.

Community Health
of Central Washington

Discounted Fee Program

February 1, 2024 – January 31, 2025

CHCW's standard fees are discounted based on the current Department of Health and Human Services Federal Poverty Guidelines, as follows.

Table showing Nominal Fee and Board of Directors approved Sliding Fee Scale Discounts Effective 2/1/2024.
For families/households over 12 persons, add $5380 for each additional person.

# of Family/Household members	SFSD A		SFSD B		SFSD C		SFSD D		Self-Pay
Federal Poverty Level (FPL)	0%	100%	101%	133%	134%	166%	167%	200%	Over 200%
1	$ -	$15,060	$15,061	$20,030	$20,031	$25,000	$25,001	$30,120	$30,121
2	$ -	$20,440	$20,441	$27,185	$27,186	$33,930	$33,931	$40,880	$40,881
3	$ -	$25,820	$25,821	$34,341	$34,342	$42,861	$42,862	$51,640	$51,641
4	$ -	$31,200	$31,201	$41,496	$41,497	$51,792	$51,793	$62,400	$62,401
5	$ -	$36,580	$36,581	$48,651	$48,652	$60,723	$60,724	$73,160	$73,161
6	$ -	$41,960	$41,961	$55,807	$55,808	$69,654	$69,655	$83,920	$83,921
7	$ -	$47,340	$47,341	$62,962	$62,963	$78,584	$78,585	$94,680	$94,681
8	$ -	$52,720	$52,721	$70,118	$70,119	$87,515	$87,516	$105,440	$105,441
9	$ -	$58,100	$58,101	$77,273	$77,274	$96,446	$96,447	$116,200	$116,201
10	$ -	$63,480	$63,481	$84,428	$84,429	$105,377	$105,378	$126,960	$126,961
11	$ -	$68,860	$68,861	$91,584	$91,585	$114,308	$114,309	$137,720	$137,721
12	$ -	$74,240	$74,241	$98,739	$98,740	$123,238	$123,239	$148,480	$148,481

Type of Service	SFSD A	SFSD B	SFSD C	SFSD D	Self-Pay Patients
Medical Services Discount	$20 Nominal Fee	$40 Co-payment	$65 Co-payment	$85 Co-payment	No Discount
Dental Services Discount	$45 Nominal Fee	$85 Co-payment	$105 Co-payment	$125 Co-payment	No Discount
Mental Health Discount	$5 Nominal Fee	$5 Co-payment	$5 Co-payment	$5 Co-payment	No Discount
Pharmacy Discount	$5 Fee + Cost of Prescription Drug	$7 Fee + Cost of Prescription Drug	$8 Fee + Cost of Prescription Drug	$9 Fee + Cost of Prescription Drug	No Discount

Patients in SFSD categories B, C, and D; will pay the lesser of the charges or the co-payment.

Pharmacy Services: Prescription Drugs are provided at cost plus a dispensing fee for all medications to patients who are under 200% of the Federal Poverty Level. Self-Pay patients will pay the full retail amount plus a dispensing fee. Payment in full is required at the time of dispensing. ***Services excluded from the SFSD** – Prosthetics, dentures, bleaching, cosmetic surgery, and services provided by other providers who are not part of CHCW. Services discounted separately by the provider (not a CHCW provider); Laboratory services provided by Quest Diagnostics Laboratory, Comprehensive Mental Health Psychiatric consultations, OB Laborist services, referrals to People for People, Valley Imaging Gyn Ultrasound services and Yakima Valley Radiology professional over read fees for X-Rays performed at CHCW.

No patient will be denied services due to inability to pay – Please speak to a patient Financial Counselor if you have questions about your account. Financial Counselors can be reached toll free at 833-574-6100; 8:00 AM to 4:00 PM Monday – Friday; except for Holidays.