



HMHD Rural Health Clinic - Discounted/Sliding Fee Policy

Department: Business Office/Clinic	Department Director/Manager: Director of Revenue Integrity
Initial/Revision Date 2/2020	Reviewed Date:
Administration: CEO	Page number:
Hospital <input checked="" type="checkbox"/>	Clinics <input checked="" type="checkbox"/>
	Senior Enrichment <input checked="" type="checkbox"/>

It is the policy of Hamilton Memorial Rural Health clinic to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to services received at this clinic, but not those services which are performed at Hamilton Memorial Hospital or are referred outside, including laboratory, drugs and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This form must be completed for each visit. Please inquire at the front desk if you have questions.

Please find the family size of your household income on the left and circle it. Only include yourself, spouse, legal dependents under 18 years of age.

# of Family Members	Income	Full Write-Off < 200% Poverty level Up to	75% Discount 201%-235% Poverty level From To		50% Discount 236%-270% Poverty level From To		2% Discount 271%-300% Poverty level From To		No Discount > 300% Poverty level
1	Annual	25,520.00	25,520.01	29,986.00	29,986.01	34,452.00	34,452.01	38,280.00	38,280.01
2	Annual	34,480.00	34,480.01	40,514.00	40,514.01	46,548.00	46,548.01	51,720.00	51,720.01
3	Annual	43,440.00	43,440.01	51,042.00	51,042.01	58,644.00	58,644.01	65,160.00	65,160.01
4	Annual	52,400.00	52,400.01	61,570.00	61,570.01	70,740.00	70,740.01	78,600.00	78,600.01
5	Annual	61,360.00	61,360.01	72,098.00	72,098.01	82,836.00	82,836.01	92,040.00	92,040.01
6	Annual	70,320.00	70,320.01	82,626.00	82,626.01	94,932.00	94,932.01	105,480.00	105,480.01
7	Annual	79,280.00	79,280.01	93,154.00	93,154.01	107,028.00	107,028.01	118,920.00	118,920.01
8	Annual	88,240.00	88,240.01	103,682.00	103,682.01	119,124.00	119,124.01	132,360.00	132,360.01
		For family units with more than 8 members, add			\$4,480	for each additional member.			

If you qualify for a discount, you must provide one of the following to show proof of income:

- Last 60 days of paycheck stubs
- Most recent tax return or W2 form
- Letter from employer stating wages for last 60 days.



Patient Name: _____ Birthdate: __/__/__

List other names & birthdates of household members:

_____	__/__/__
_____	__/__/__
_____	__/__/__
_____	__/__/__
_____	__/__/__
_____	__/__/__

I certify that the family size and income information shown above is correct.

Signature

Date