**PATIENTS COPY**

WASHINGTON COUNTY MEMORIAL HOSPITAL

## Sliding Scale Guidelines/Requirements

- You, the patient, must complete and turn in:
    1. Determination for Medicaid Eligibility Form and/or Medicaid Application
    2. Sliding Scale Application
    3. Proof of Income, one of the following - Last 3 months income, Last year's tax return, Copy of bank statements, Disability Letter, Unemployment Letter, Food Stamp Budget Summary Worksheet (If no income, you must have written verification of who is paying your bills or loaning you money, all proof of income from the other parties helping you out)
    4. Pay $35.00 at the time of service for primary care, or $85.00 for specialty care

        ***Please note that if you DO NOT pay your $35.00/$85.00 at the time of service, you WILL NOT qualify for Sliding Scale***

- NOTE: If you have previously applied and have not complied with all the guidelines, you will **NOT** be eligible to reapply for 6 months and any balance you have from your previous application/visits must be cleared. NO PAYMENT AGREEMENTS WILL BE MADE.
- If you are approved for Sliding Scale – the staff at WCMH will let you know at what level, and how much your visits will cost for the next 6 months.
- BE ADVISED: If you have a more extensive visit and/or have additional testing done while in the office, YOU WILL BE RESPONSIBLE AT FULL PRICE FOR THOSE SERVICES.
- All applications are good for 6 months.
- The minimum amount you will pay at every visit is $35.00.

# SLIDING SCALE INFORMATION

WASHINGTON COUNTY MEMORIAL HOSPITAL

WCMH will offer financial assistance to uninsured patients of limited financial means. This service is based upon the patient's income. If you are a patient and seeing our specialist you will be expected to pay $85. For patients being seen by primary care, you may expect to pay $35.00 on your first visit and $35.00 for any follow up visits (plus any additional tests or procedures done that day). These discounted prices must be paid in full at time of service. NO EXCEPTIONS.

***Chiropractic visits *do NOT* qualify for Sliding Scale***

Below you will find a list of documentation that is needed in order to qualify for this service.

1. PROOF OF INCOME FOR THE PAST 3 MONTHS OR PREVIOUS YEAR TAX RETURN.
2. DENIAL LETTER FROM MEDICAID WITHIN THE LAST MONTH, DETERMINATION FOR MEDICAID ELIGIBILITY FORM, OR LETTER SHOWING PENDING APPLICATION.
3. SLIDING SCALE APPLICATION

All information must be turned in at the time your appointment or within 10 days of service.

Patients must reapply every 6 months and present the same qualifying documentation at that time.

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I HAVE READ AND UNDERSTAND THE ABOVE. I ACCEPT FULL RESPONSIBILITY OF PROVIDING THE CORRECT INFORMATION TO THE WCMH BILLING OFFICE SHOULD I FAIL TO PROVIDE THE REQUESTED INFORMATION. I WILL BE CHARGED THE ENTIRE OFFICE VISIT MINUS ANY AMOUNT THAT WAS COLLECTED AT THE TIME OF SERVICE.

_____ _____

PATIENT NAME DATE

PATIENT RECEIVED COPY YES_____NO_____ STAFF INITIALS_____

Effective: 12/30/15

WASHINGTON COUNTY MEMORIAL HOSPITAL

# State of Missouri
# Financial Screening Protocol

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Contact Phone #: _____ Patient Account #: _____

(Circle the correct answer to each of the questions below)

Part I

- Do you currently have a pending Medicaid application? YES or NO
- Are you the parent of minor children? How many? _____ YES or NO
  - If yes, does the child live in the home with you? YES or NO
  - If yes, does either biological parent in the household work? YES or NO
  - If yes, what is the gross monthly income? _____

Medicaid income guidelines for Parents of minor children in MO:

| Household Size | Income Amount | Household Size | Income Amount |
|---|---|---|---|
| 2 | $241 | 5 | $400 |
| 3 | $301 | 6 | $445 |
| 4 | $353 | 7 | $490 |

Part II

- Are you pregnant? Have you been pregnant in the last 3 months? YES or NO
- Are you currently age 65 or older? YES or NO
- Are you currently receiving Social Security income based on a disability? YES or NO
  - If yes, how much? _____
- Are you blind? YES or NO
- Are you currently unable to work due to a physical or mental disability? YES or NO
  - If yes, what is your disabling condition? _____

- Is the patient a child under the age of 19? YES or NO

*I do certify that the information I have provided today is true and accurate to the best of my knowledge.*

_____ _____

Patient Signature Date

This application will be reviewed by the WCMH financial team to determine if you could be eligible for Medicaid. If you are deemed eligible, our Patient Accounts department will contact you for further information.

***NOTE—This is NOT a WCMH Financial Assistance Application.

WASHINGTON COUNTY MEMORIAL HOSPITAL

# Application for RHC Sliding Scale

Submit completed application to the clinic in which sliding scale is applied for.

THE INFORMATION REQUESTED ON THIS APPLICATION WILL BE USED TO ASSIST IN DETERMINING ELIGIBILITY. APPLCIANT *WILL BE REQUIRED* TO SHOW PROOF OF INCOME. APPLICATION MUST BE COMPLETE. DEPENDENTS ARE CHILDREN AND OTHER DEPENDANTS WHO ARE LIVING WITH THE APPLICANT AND ARE CLAIMED AS DEPENDANTS ON FEDERAL AND STATE INCOME TAX FILINGS.

NAME (Last, First, Middle Initial):_____

ADDRESS (Street, City, State, Zip):_____

PHONE:_____ SSN: (optional)_____

LAST EMPLOYMENT (Company name, address, date last worked):

_____

TOTAL FAMILY GROSS INCOME FOR THE LAST 12 MONTHS: $_____ TOTAL NUMBER IN FAMILY:_____

PLEASE LIST FAMILY NAMES AND AGES

NAME_____ AGE:____ NAME_____ AGE:____

NAME_____ AGE:____ NAME_____ AGE:____

NAME_____ AGE:____ NAME_____ AGE:____

NAME_____ AGE:____ NAME_____ AGE:____

TYPE OF SERVICE RENDERED OR REQUESTED:_____

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc) which may be available for payment of my hospital charge, and will assign or pay to the hospital the amount recovered for hospital charges. I understand the information submitted is subject to verification by Washington County Memorial Hospital. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever legal action becomes appropriate.

DATE:_____ APPLICANTS SIGNATURE:_____

FOR OFFICE USE ONLY

MONTHLY GROSS INCOME_____ X 12=_____ No. in Family_____

125% X Poverty guideline for family size =_____ Denied:_____

Approved:_____

Full_____ Partial_____

Staff Signature:_____

Revised 10/2/2020