

DISCOUNT FEE SCHEDULE

Annual Household Income

(Based Upon Federal Register, Vol. 74, No. 14, January 23, 2009)

	Financial Class A	Financial Class B	Financial Class C	Financial Class D
Patient Pays	\$25 Minimum Payment for E/M +25% of Other Procedure Codes	\$35 Minimum Payment for E/M +50% of Other Procedure Codes	\$45 Minimum Payment for E/M +75% of Other Procedure Codes	Full Payment for services rendered 25% Discount for Full Payment at Time of Service
Family Size	<i>0-100%</i> <i>Federal Poverty</i> <i>Level</i>	<i>101-150%</i> <i>Federal Poverty</i> <i>Level</i>	<i>151-200%</i> <i>Federal Poverty</i> <i>Level</i>	<i>Greater than</i> <i>200% of Federal</i> <i>Poverty Level</i>
1	\$10,830	\$16,245	\$21,660	>\$21,660
2	\$14,570	\$21,855	\$29,140	>\$29,140
3	\$18,310	\$27,465	\$36,620	>\$36,620
4	\$22,050	\$33,075	\$44,100	>\$44,100
5	\$25,790	\$38,685	\$51,580	>\$51,580
6	\$29,530	\$44,295	\$59,060	>\$59,060
7	\$33,270	\$49,905	\$66,540	>\$66,540
8	\$37,010	\$55,515	\$74,020	>\$74,020
For Each Additional Person, Add	\$3,740	\$5,610	\$7,480	\$7,480

Note: Minimum payments are for E/M office visits only. All other procedure codes are to be paid at the discounted percentage rate as indicated.

Minimum payment can be waived in cases of hardship. All applications will be considered for a 30-day retroactive time frame and retroactive decisions will be made on a case-by-case basis.

Effective February 9, 2009

Gross Income		Liabilities/Debts/Monthly Payments	
Unemployment	\$	Rent or Mortgage	
Child Support/Allimony/ AFDC	\$	Payment (monthly)	\$
Social Security/Disability	\$	Vehicles	\$
Pension/Retirement Trust	\$	Bank Loans	\$
Employment Income	\$	Other	\$
Other Income	\$	Total Outstanding	
Income last 12 mo.	\$	Monthly Debts	\$
Income last 3 mo.	\$	Court Judgements	\$
Assets			
Cash on Hand	\$	Vehicles	\$
Balance in checking	\$	Collateral (other than	
Balance in savings	\$	real estate)	\$
Real Estate-rent or own	\$	Total Assets	\$

I will furnish to the best of my ability, proof of the above income categories. I affirm that this statement of family annual income of \$ _____ is true and accurate to the best of my knowledge, and that all statements made by me in this application are true. I understand that the information is subject to verification by LaPine Community Health Center and is subject to review by federal and/or state enforcement agencies and others as required.

Signature of Applicant

Date

The following should be completed by LaPine Community Health Center

Date application received: _____ *Received by:* _____

The following documents were provided to verify income, Pay Stubs: _____ *Income Tax*
Returns _____ *Bank Statements* _____ *Other* _____

Discount _____ *Valid Date* _____ *through* _____

Approval Signature

Date

