



Watts Healthcare Corporation

SLIDING FEE SCALE *DISCOUNT PROGRAM*

The Watts Healthcare Corporation (WHCC) offers a Sliding Fee Scale (SFS) Discount program for low-income and/or uninsured patients. [See attached Sliding Fee Scale \(SFS\) Discount Program Scale.](#)

MEDICAL SERVICES

See attached Sliding Fee Scale (SFS) Discount Program for Medical Services

Nominal Fee: Patient pays \$30.00 for office visit

Level B: Patient pays \$35.00 for office visit

Level C: Patient pays \$40.00 for office visit

Level D: Patient pays \$50.00 for office visit

Level E: Patient pays \$80.00 for office visit

- Levels B and above will not pay less than the Nominal Fee.
- Patients above 200% FPL are not eligible for Sliding Fee Scale Discounts.
- We request payment of the Sliding Fee Scale Discount Fee at the date of service.
- There is a 50% discount for Same Day Clinic Services after hours.

What is not covered under Sliding Fee Scale (SFS) Discount Program?

- Medications - Prescriptions
- Out of Scope Services (Services that are not required or additional in WHCC's federal scope of services)

Services not covered may be covered by enrolling and qualifying into other health coverage programs.

DENTAL SERVICES

See attached Sliding Fee Scale (SFS) Discount for Dental Services

Nominal Fee: Patient pays \$50.00 for office visit

Level B: Patient pays \$55.00 for office visit

Level C: Patient pays \$ 60.00 for office visit

Level D: Patient pays \$70.00 for office visit

Level E: Patient pays \$100.00 for office visit

- Levels B and above will not pay less than the Nominal Fee.
- Patients above 200% FPL are not eligible for Sliding Fee Scale Discounts.
- We request payment of the Sliding Fee Scale Discount Fee at the date of service.

What is not covered under Sliding Fee Scale Discount Program for Dental Services?

- Medications - Prescriptions
- Outside laboratory fees (charged at WHCC cost)
- Supplies (charged at WHCC cost)
- Out of Scope Services (Services that are not required or additional to WHCC's federal scope of services)



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SLIDING FEE SCALE *PROGRAM CONDITIONS*

NO patient is denied services for inability to pay.

1. To qualify for the Sliding Fee Scale (SFS) Discount Program, you must bring your family's proof of income within 10 days.
 - a. Proof of Income: 2-4 pay stubs, tax forms, a letter from employer, documents verifying amount of income from other sources, ex. Unemployment, SSI, alimony, child support etc.
 - b. If you do not have your proof of income at your first visit/appointment, you may estimate your family's current gross annual income but bring documentation to the health center within 10 days.
2. If your proof of income is eligible, you will receive a discount for 6 months. Patients must re-apply for the sliding fee scale program after 6 months.
3. You may be eligible for Medi-Cal, My Health LA, Covered California or other subsidized health coverage programs. Although it is not a requirement to enroll in our Sliding Fee Scale Discount Program, we can help you make an appointment with a certified enrollment counselor to determine whether you are eligible for these programs.
4. If you fail to bring us your proof of income within the specified date below, you may be charged the cost for your next visit. No patient is denied care for inability to pay.
5. What is not covered under Sliding Fee Scale (SFS) Discount Program for Medical Services?
 - Medications - Prescriptions
 - Out of Scope Services (service not required or additional in WHCC's federal scope of services)
6. What is not covered under Sliding Fee Scale (SFS) Discount Program for Dental Services?
 - Medications - Prescriptions
 - Supplies (charged at WHCC costs)
 - Out of Scope Services (services not required or additional in WHCC's federal scope of services)

I understand that I need to bring in my Proof of Income by _____ to receive my Sliding Fee Scale Discount status.

NO patient is denied services for inability to pay.



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SLIDING FEE SCALE *APPLICATION FORM*

Today's Date		Name				
Date of Birth		Address				
City				State		ZIP Code
Home Phone			Work Phone			Cell Phone
<p>Would you like to schedule an appointment with a Certified Enrollment Counselor to see if you and/or household members are eligible for Medi-Cal or subsidized health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
<p>Applying for health coverage is NOT a prerequisite for Sliding Fee Scale (SFS) Discount eligibility.</p>						

Please list all immediate family members and persons living in your household (spouse or life partner and children that are *under the age of 19 years*) and that are dependent on family income. Please do not include guests, elderly parents or roommates.

Name of Family Members	Sex	Date of Birth	'X' if no health insurance	Has insurance? Type: Medi-Cal, Medicare Private, Covered California, or Other (please specify)
1. (Self)				
2. (Spouse)				
3. (Child)				
4. (Child)				
5. (Child)				



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What is your gross family income BEFORE deductions? Please include below all working adults, above age 19:

Name of Household members receiving income	Estimated Annual income (per person) (monthly income x 12)	Sources of Income (Employment, social security, pension, retirement, worker's compensation, child support, alimony, etc.)	Proof of Income Date Requested/ Date Verified	WHCC Staff Notes
1. (Self)	\$			
2.	\$			
3.	\$			

I certify that the income and household composition information is true and correct to the best of my knowledge. I have read the Sliding Fee Scale (SFS) Discount Application and I will abide by all SFS Discount requirements.

- 1. I understand and agree that I am responsible for notifying Watts Healthcare Corporation of any changes in my household size or income by completing a new application.**
- 2. I understand that my SFS Approval is good for six months from the date of approval with all required documents.**
- 3. I understand that I am responsible for paying my office visit co-pay at the time of service along with any other charges that I may incur during my visit. I.e. Labs, Procedures and x-rays.**
- 4. I understand that if I do not provide all required documentation within 10 days of this application I will not be approved for a Sliding Fee Discount and I will be responsible for all charges incurred at my next visit.**

Applicant Signature		Date	
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Please bring your proof of income within 10 days of submitting application.

STAFF USE ONLY:

WHCC Staff: _____ Date: _____ SFS Termination Date _____

Per your estimated monthly income of \$ _____ and a family size of _____ you qualify for SFS level _____ (10 days -Pending Status).

Based on your monthly income of \$ _____ and a family size of _____ you qualify for SS level _____ (6 months).

For each office visit, patient will pay: \$ _____ (Primary Care) \$ _____ (Dental) which does not include laboratory fees, medications, x-rays and supplies at cost. Patient is responsible for these additional costs.



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You may also be eligible for the following health coverage programs:

Publically Subsidized Health Insurance Programs

- Covered California
- Medi-Cal for Kids & Adults
- Medi-Cal Access Program (program for pregnant women)

Publically Subsidized Programs for Uninsured Individuals

My Health LA: Primary Care, Dental

- **My Health LA:** Primary Care and Dental Care
- **Every Woman Counts:** Cervical Cancer and Mammogram Screening
- **CHDP:** Physicals and immunizations for children 0-18 years of age
- **CPSP:** Comprehensive Perinatal Care
- **Fam PACT:** Birth control, family planning, STD screening, pregnancy testing, PAP test
- **CALFRESH:** Nutrition Assistance Program (SNAP)

WHCC Classes & Counseling

- Health Education
- Diabetes
- Substance Abuse
- Nutrition
- Smoking Cessation
- Behavioral Health