



Sliding Fee Program

Sliding Fee is a special program offered at KFMC to assist those who are uninsured or have difficulty paying for medical care. The program offers our patients a broad range of services, including medical, laboratory, x-ray, dental, and behavior health. Sliding Fee discounts are offered at all of our locations. You may apply regardless of whether you have insurance coverage or not. You must meet income guidelines which are based on family size and family gross income. Proof of income is required and must be current. A list of required sources of income can be found below.

HOUSEHOLD = Applicant + Spouse/Significant Other + Legal Tax Dependents

Sliding Fee Income Requirements

January 31, 2017

Family Size	0%	20%	40%	60%	80%	100%
1	\$0 - 12,060	\$12,061 - 15,075	\$15,076 - 18,090	\$18,091 - 21,105	\$21,106 - 24,120	over
2	\$0 - 16,240	\$16,241 - 20,300	\$20,301 - 24,360	\$24,361 - 28,420	\$28,421 - 32,480	over
3	\$0 - 20,420	\$20,421 - 25,525	\$20,256 - 30,630	\$30,631 - 35,735	\$35,736 - 40,840	over
4	\$0 - 24,600	\$24,601 - 30,750	\$30,751 - 36,900	\$36,901 - 43,050	\$43,051 - 49,200	over

For each additional family member add \$4,180 to the base. Reference: Federal Poverty Level Guidelines, 2017.

If your application has not been pre-approved, be prepared to pay the FULL amount at the time of service.

Required proof of income includes the following:

- Current Slide Application (completed/signed/dated)
- Most recent Income Tax Return form **OR** (if no tax return) a signed/dated 4506T IRS form
- If self-employed, complete tax return + the Schedule C/CEZ + depreciation schedule
- The previous month's paystubs (of everyone working within the household, see below definition of household) **OR** a statement from your employer stating GROSS income for last month
- A copy of any benefit checks (Social Security, Pensions, Veteran's benefits, Disability, Unemployment, Alimony, Child Support, Military LES, Food Stamps, etc.) **OR** a copy of their bank statement (if check is directly deposited into their account)
- Self Declaration of Income/Statement of Personal Assistance Letter (if no/limited income)

You may submit the completed application with all required proof of income to any of our facilities (or mail them to: KFMC SF Coordinator, PO Box 180, Battiest, OK 74722). **If the application is missing any of the above income information or is not signed, it will be denied. Incomplete applications will be considered void if all information is not received within 30 days.**

If you have any questions, please call (580)241-5294, or visit our website at www.kiamichimed.org.

KFMC Sliding Fee Application

<input type="checkbox"/>	1st Time Application
<input type="checkbox"/>	Renewal

Applicant: _____

Home Phone: _____

Address: _____

Cell Phone: _____

City/State/Zip: _____

Email: _____

I certify that all statements contained herein are true and correct and subject to investigation. I also authorize the release of employment records and other financial information to an agent of KFMC for sliding fee determination purposes.

Signed: _____

Date: _____

Did you file a tax return last year?	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you receive SSI or Disability income?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are any adults in the household currently working?	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you have Medicare health insurance?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you receive food stamps?	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you have Medicare Part B insurance?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you receive any public assistance?	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you have Medicare Part D insurance?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you receive Child Support or Alimony?	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you or your kids have Soonercare/Medicaid?	<input type="checkbox"/> yes <input type="checkbox"/> no

Applicant _____
 Employer _____
 Employer Address _____
 Health Insurance _____

Date of Birth _____ SSN _____
 Hourly Wages \$ _____ Hours/week _____
 Annual/Monthly Salary \$ _____ Child Support \$ _____
 Any Other Income \$ _____
 Pharmacy Insurance coverage? yes no

Spouse/Significant other _____
 Employer _____
 Employer Address _____
 Health Insurance _____

Date of Birth _____ SSN _____
 Hourly Wages \$ _____ Hours/week _____
 Annual/Monthly Salary \$ _____ Child Support \$ _____
 Any Other Income \$ _____
 Pharmacy Insurance coverage? yes no

OTHER MEMBERS OF THE HOUSEHOLD: List the other family members living in your household that you can legally claim as tax dependents (proof required). List additional family members on the back of this sheet.

Name _____
 Relationship to Applicant _____
 Health Insurance _____
 Primary Care Physician _____

Is he/she a legal tax dependent? yes no
 Date of Birth _____ SSN _____
 Employer _____
 Annual Income \$ _____ Other Income \$ _____

Name _____
 Relationship to Applicant _____
 Health Insurance _____
 Primary Care Physician _____

Is he/she a legal tax dependent? yes no
 Date of Birth _____ SSN _____
 Employer _____
 Annual Income \$ _____ Other Income \$ _____

THIS SECTION TO BE COMPLETED BY THE KFMC STAFF

Front Office Checklist

- Most recent Income Tax Return OR a 4506T IRS Form
- If self-employed – the Schedule C or CEZ tax forms
- Last/Previous month's pay stubs
- Benefit Checks (Unemployment/Disability/SSI/Alimony/Child Support)
- Income/Food Stamp verification from DHS **OR**
- Self Declaration of Income (if no/limited income)
- Statement of Personal Assistance (if no/limited income)

Application Received By: _____ / _____
 Date Initials

Total Household Gross: \$ _____
 Family Size: _____

of children in household: _____

Level: 0% 20% 40% 60% 80% 100%