NORTHEAST MISSOURI HEALTH COUNCIL
Partners for a Lifetime of health

Northeast Missouri Health Council, Inc.

SLIDING FEE SCALE REQUIREMENTS

Northeast Missouri Health Council offers a need-based sliding fee scale to help make healthcare costs more affordable for qualifying patients. The sliding scale is based on family size and income level up to 200% of the current Health and Human Services Poverty Guidelines.

APPLICATION FORM

Applicant Names
Date of Birth
Total Income from 1040 Tax Return and Income for all individuals

PROOF OF INCOME FOR THE HOUSEHOLD

Required when an income tax return has been filed

a) IRS 1040 Income Tax Form

- Dependents listed on IRS 1040 ages 18 and over must provide one of the following:
  - Two letters of unemployment if not working
  - IRS 1040
  - Copy of pay stubs for prior month
  - W-2

Required when an income tax return has not been filed

One (1) of the following acceptable proofs of income

- **Copy of most current W-2 -** use Box 1 as Gross Income
- **Copy of pay stubs** for all incomes for 1 month (a minimum of 2 stubs if paid monthly)
- **Self-employed individuals** must provide accounting of income or quarterly tax payments
- **Social Security** will **NOT** be counted as household income for purposes of determining slide eligibility and category.
- **Two letters (2)** from non-family members confirming that the patient has no income. The letter should include printed name, signature and date.

- Discounts will be applied ONLY 30 days prior to the completion of the application.
- The slide information covers the current fiscal year (April through March), and only individuals listed on the application are covered.
- Slide category is based only on the number of qualified individuals and income verification.
- **Your copay is due at the time of service**.

Please contact the NMHC Billing office at 660-627-5757 if you have any questions.

SERVICES CANNOT BE DISCOUNTED UNTIL THE APPLICATION AND CONFIRMATION OF INCOME ARE COMPLETED.

Updated 3/2025

Northeast Missouri Health Council
Application for Sliding Fee Scale Discount

Due Back Approx
____/____/____

The Northeast Missouri Health Council, Inc. may be able to offer services at a discounted price based on the number of members in your household and your combined income. If you wish to determine the amount of discount available to you, the following information is required. Information reported should be as accurate and complete as possible and will be kept completely confidential.

*HOH	Entered in UDS	Last Name	First Name	Marital Status	DOB	Age	Relationship to applicant
							Self

Your discount will apply to all our clinics, but <u>not all services</u> are covered by the sliding fee program. Please inquire before services are provided if you need to be informed of covered services.

If you have insurance, your signature on this form is our release to file your insurance for the full amount of services provided. The clinic is entitled to recover the full amount charged from insurance and will slide off the balance <u>only</u> after all insurance payments or denials have been received.

If proof of income is not received and the slide application is not completed <u>within 30 days of services</u>, the patient must pay the full charge. The application qualifies the individuals listed above for the slide category determined for the entire current fiscal year based on the date the application is completed. Our fiscal year is from April 1 through March 31 and a new application must be completed every fiscal year.

I have read and understand all of the information. All information recorded is correct, truthful and complete. If there is a change in the number of applicants or my financial situation, I will contact the clinic immediately and re-apply if necessary.

Date_____/_____/_____ Applicant Signature_____

BELOW THIS LINE IS FOR OFFICE USE ONLY

****

	Proof of Income Documents	Date received
	If patient filed a recent Tax Return	
	(1) Most Recent Income Tax Return for confirmation of Adjusted Gross Income	
	If patient did not file tax return, ONE of the following must be provided	
	(1) Copy of most current W-2 (use figure in Box 1 for total patient income)	
	(2) Copy of pay stubs (for all incomes for a minimum of 1 month)	
	(3) Self-employed individuals must provide some accounting of income or quarterly tax payments	
	(4) Two (2) letters from non-family confirming the patient has no income	

Total number of applicants: _____ **Annual verified income:** $_____

Slide Category: _____ Completed by: _____ Date ___/___/____

Updated 3/2025