Western Sierra Medical Clinic
a californiahealth+ center

Sliding Fee Application

wsmcmed.org

It is the policy of Western Sierra Medical Clinic, Inc., to provide essential quality services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk or billing department to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at all Western Sierra locations, but not those services which are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. Nor will this approval be applied retroactively to prior services.

Family Assistance Plan Application

Name of Head of Household	Place of Employment
Street, City, State Zip	Phone, cell phone, message phone
Health Insurance Plan	Social Security Number

Please list spouse and dependents under age 18

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual Household Income

Source	Self	Spouse	Significant Other	Other	Total
Gross Wages, salaries, tips, etc.					
Social security, pension, annuity, and veteran's benefits					
Alimony, child support, military family allotments					
Income from business self-employment, and dependents					
Self-Declaration (additional form)					
Total Income					

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's License, birth Certificate, employment ID, social security card or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance cards(s)		
Medicaid: Application made or evidence of rejection		

15 Calendar Day Grace Period Expires On: _____

I have been advised that I must provide proof of income to the clinic within fifteen (15) days to receive a discount for my visit on _____ and that if I do not do so by the above expiration date, I will be required to pay 100% of the fee. I understand that the sliding fee discount does not apply to medications, services which are purchased from outside, including reference laboratory testing, drugs, x-ay interpretation by a consulting radiologist, and other such services or services provided at the clinic by independent specialists or service providers. **I understand that a nominal fee of $25.00 for medical and mobile, $35.00 for dental and $50 for Psychiatrist is expected at the time of service**. The sliding fee discount is a resource of last resort. Applicants who may qualify for other resources, such as Medi-Cal, Healthy Families, and Veteran's benefits, must apply for these programs, in compliance with the Western Sierra Medical/Mobile/Dental Clinic's sliding fee policy. Additionally, in order to remain eligible you must keep your account in good standing for yourself and your immediate family members. A balance 90 days outstanding will disqualify you for Western Sierra Medical Clinic's sliding fee discount. ***Services will be not denied based on ability to pay.***

I certify that the information shown above is correct and understand verification is required for approval. If it is discovered, that I have knowingly provided false information, I understand that I will not be eligible for sliding fee discounts for one year from the date of this application.

_____ _____

Name (Print) Signature (Date)