Services Covered and Excluded

Winner Regional Clinic

Discounted / Sliding Fee Application

Winner Regional Health
Locally Owned and Operated

It is the policy of Winner Regional Clinic to provide essential 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 to determine if you or members of your family are eligible for a discount.

The discount will apply to all services at this clinic, but not those services which are purchased from outside including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. In the hopes that your financial situation improves, discounts apply only to current, not future services. This application, if approved will be effective for six months, after which the patient must re-apply. Please inquire at the front desk if you have questions.

Number of related persons living in your household: _____

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependent Children (under age 18)			
Total			

Note: Include income from all sources includes gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business income or self-employment income, alimony, child support, military, unemployment, and public aid.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name: _____

Date: _____

Signature: _____

Office Use Only

Patient Name	
Date of Service	
Discount % and Approved By	

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Winner Regional Clinic

Family Assistance Plan Application

Name of Head of Household	
Place of Employment	
Address	
Phone	
Health Insurance Plan	
Social Security Number	

Please list spouse and dependents under age 18

Name	**Date of Birth**

Annual Household Income

Source	**Self**	**Spouse**	**Other**	**Total**
Gross wages, salaries, tips, etc.				
Social Security, pension, annuity, and veteran's benefits				
Alimony, child support, military, family allotments				
Income from self-employment and dependents				
Rent, interest, dividend and other income				
Total Income				

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name: _____

Date: _____

Signature: _____

Office Use Only

Patient Name	
Date of Service	
Discount % and Approved By	

Verification Checklist (attach copies)

	Yes	**No**
Identification/Address: Driver's license, employment ID, social security card, etc.		
Income: Prior year tax return, three most recent pay stubs, or other		

Sliding Fee Scale
Based on Federal Register 2023 Poverty Guidelines

Family Size	Income Measure	Category 0	Category 1	Category 2	Category 3	Category 4
% of Federal Poverty Income Level		Up to 100%	100.01%-149.99%	150.00%-174.99%	175.00%-199.99%	200.00%+
		Patient Fee: $0.00	Patient Fee: $10.00	Patient Fee: $20.00	Patient Fee: $30.00	Patient Fee: 100%
1	Annual Monthly	$0 – $14,580 $0 – $1,215	$14,581 – $21,869 $1,216 – $1,822	$21,870 – $25,514 $1,823 – $2,126	$25,515– $29,160 $2,127 – $2,430	$29,161 + $2,431+
2	Annual Monthly	$0 – $19,720 $0 – $1,643	$19,721 – $29,579 $1,644 – $2,464	$29,580 – $34,509 $2,465 – $2,875	$34,510 – $39,440 $2,876 – $3,286	$39,441 + $3,287 +
3	Annual Monthly	$0 – $24,860 $0 – $2,072	$24,861 – $37,289 $2,073 – $3,108	$37,290– $43,504 $3,109 – $3,626	$43,505– $49,720 $3,627– $4,144	$49,721 + $4,145 +
4	Annual Monthly	$0 – $30,000 $0 – $2,500	$30,001 – $44,999 $2,501– $3,750	$45,000 – $52,499 $3,751 – $4,375	$52,500 – $60,000 $4,376– $5,000	$60,001 + $5,001 +
5	Annual Monthly	$0 – $35,140 $0 – $2,928	$35,141 – $52,709 $2,929– $4,392	$52,710 – $61,494 $4,393 – $5,124	$61,495 – $70,280 $5,125 – $5,856	$70,281+ $5,857+
6	Annual Monthly	$0 – $40,280 $0 – $3,357	$40,281 – $60,419 $3,358 – $5,035	$60,420 – $70,489 $5,036 – $5,874	$70,490 – $80,560 $5,875 – $6,714	$80,561 + $6,715 +
7	Annual Monthly	$0 – $45,420 $0 – $3,785	$45,421 – $68,129 $3,786 – $5,677	$68,130 – $79,484 $5,678 – $6,623	$79,485 – $90,840 $6,624 – $7,570	$90,841 + $7,571 +
8	Annual Monthly	$0 – $50,560 $0 – $4,213	$50,561 – $75,839 $4,214 – $6,319	$75,840– $88,479 $6,320 – $7,372	$88,480– $101,120 $7,373 – $8,426	$101,121 + $8,427+
Each additional family member		+ $5,140 A + $428 M	+ $5,140 A + $428 M	+ $7,710 A + $642 M	+ $8,995 A + $750 M	+ $10,280 A + $857 M

EXCLUSIONS - CATEGORY 0

MEDICAL

The following will be billed at 100% of PHN's actual costs:

- Injectables

DENTAL

The following will be billed at 100% of PHN's actual costs:

- Dental lab cost associated with dentures, crowns or bridge work

EXCLUSIONS - CATEGORY 1-3

MEDICAL

The following will be billed at 100% of the actual charge based on PHN's fee schedule:

- Some in-office surgeries/procedures
- Certain Injectables
- Off-site services, such as hospital, hospital services, and nursing homes

DENTAL

The following will be billed at 75% of the actual charge based on PHN's fee schedule:

- Dentures
- Crowns
- Bridge Work
- Oral Surgery
- Resin Based Posterior Fillings