Community Health Center of Fort Dodge
Payment Policy/Sliding Fee Verification

The community Health Center of Fort Dodge strives to provide quality accessible medical care to all individuals. To ensure that we are able to provide this care, our office and procedure rates are competitive with area physician groups. Also, please note that your initial visit to the Community health Center of Fort Dodge will be billed at a higher rate than subsequent visits. Along with an office visit there may be other charges, such as lab charges, that your medical provider may request.

If you do not have insurance and would like to be evaluated for a Sliding Fee Discount, we will need financial information from the list below:

1. Four weeks of pay stubs
2. Last year's signed income tax return (For self employed)
3. Letter from SSI showing benefits (For disability Income) OR a copy of your bank statement showing Social Security direct deposit
4. Letter of denial from Iowa Medicaid showing eligibility for Permanent Sliding Fee Scale eligibility

This is information that the Federal Government requires we obtain before making a decision on your eligibility for the Sliding Fee Discount. The Sliding Fee Discount is based on family size and total household gross income.

If you do not have any of the information listed above, please ask a staff member what other documentation we might be able to accept.

Without your documentation, we are not able to offer a discount on your medical services. You will be billed a full rates if you do not qualify for a Sliding Fee discount or if you do not provide us with the necessary information.

If you have any questions regarding this statement, please ask to speak to someone in the billing or business office.

I have read and had the opportunity to discuss any questions I may have in regards to the above information. By signing this document, I am verifying that I understand my responsibility to Community Health Center of Fort Dodge in providing my financial information so that eligibility for the Sliding Fee Discount may be determined.

After evaluation of my financial information, I have been placed at the _____ Percent on the sliding fee scale.

_____ _____

Signature of patient Date

_____ _____

Signature of CHC employee Date