KIAMICHI
FAMILY MEDICAL CENTER

# 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
INCOME = All income sources for All members of the household

**Sliding Fee Income Requirements**
January 17, 2025

| Family Size | 0% | 20% | 40% | 60% | 80% | 100% |
|---|---|---|---|---|---|---|
| 1 | $0- 15,650 | $15,651- 19,563 | $19,564- 23,475 | $23,476- 27,388 | $27,389- 31,300 | over |
| 2 | $0- 21,150 | $21,151- 26,438 | $26,439- 31,725 | $31,726- 37,013 | $37,014- 42,300 | over |
| 3 | $0- 26,650 | $26,651- 33,313 | $33,314- 39,975 | $39,976- 46,638 | $46,639- 53,300 | over |
| 4 | $0- 32,150 | $32,151- 40,188 | $40,189- 48,225 | $48,226- 56,263 | $56,264- 64,300 | over |

*For each additional family member add $5,500 to the base. Reference: Federal Poverty Level Guidelines, 2025.*

**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)286-6688, or visit our website at www.kiamichimed.org.

# KFMC Sliding Fee Application

☐ 1st Time Application
☐ 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? | ☐yes☐no | Do you receive SSI or Disability income? | ☐yes☐no |
| Are any adults in the household currently working? | ☐yes☐no | Do you have Medicare health insurance? | ☐yes☐no |
| Do you receive food stamps? | ☐yes☐no | Do you have Medicare Part B insurance? | ☐yes☐no |
| Do you receive any public assistance? | ☐yes☐no | Do you have Medicare Part D insurance? | ☐yes☐no |
| Do you receive Child Support or Alimony? | ☐yes☐no | Do you or your kids have Soonercare/Medicaid? | ☐yes☐no |

**Applicant** _____ Date of Birth _____ SSN _____
Employer _____ Hourly Wages $_____ Hours/week _____
Employer Address _____ Annual/Monthly Salary $_____ Child Support $_____
Any Other Income $_____
Health Insurance _____ Pharmacy Insurance coverage? ☐yes ☐no

**Spouse/Significant other** _____ Date of Birth _____ SSN _____
Employer _____ Hourly Wages $_____ Hours/week _____
Employer Address _____ Annual/Monthly Salary $_____ Child Support $_____
Any Other Income $_____
Health Insurance _____ 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 _____ **Is he/she a legal tax dependent?** ☐yes☐no
Relationship to Applicant _____ Date of Birth _____ SSN _____
Health Insurance _____ Employer _____
Primary Care Physician _____ Annual Income $_____ Other Income $_____

Name _____ **Is he/she a legal tax dependent?** ☐yes☐no
Relationship to Applicant _____ Date of Birth _____ SSN _____
Health Insurance _____ Employer _____
Primary Care Physician _____ 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%