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Sliding Fee Discount Program

Central Ozarks Medical Center offers a Sliding Fee Discount Program (SFDP) to all individuals and families with annual incomes at or below 200% of the Federal Poverty Guidelines (FPG). The SFDP is offered for Medical, Dental, and Behavioral Health services.

To determine eligibility for the SFDP, COMC will need to ask you to bring in personal financial information. Any information we ask you to provide will be kept strictly confidential**. None of your personal information can be released without your written consent**. The information we are requesting will be used solely to determine your family size and income. Applications are effective for a one-year period. SFDP participants must complete an application annually. SFDP applications must be completed, signed and approved prior to services being provided. All participants are asked to notify COMC of changes to family size and/or income as soon as possible after the change occurs.

Family Size is defined as the number of individuals receiving financial support from a head of household and includes the following:

1. Patient applying
2. Individuals that can be claimed by the patient on a Federal/State tax return
3. Family members living with and financially supported by the patient

Income is defined as earnings used to support an individual/household unit and is generally considered to be the adjusted gross income reported for income tax purposes.

Acceptable Forms of Proof of Income include the following:

1. Most recent year's Federal IRS Form 1040 (Adjusted Gross Income)
2. Most recent pay stubs (2 consecutive)
3. Letter from employer detailing gross wages, frequency of pay periods, and dates of employment
4. Letter from Social Security, Veteran's Affairs, or Employment Office that lists income

Self-Declaration of Income

Patients must bring required information for verification of family size and income at their first visit in order to qualify for the SFDP. However, if the patient does not have the information, they can be seen for 30 days at the slide level determined from a completed self-declaration form. Patients with no income may also complete a self-declaration form and be seen at slide level A for 30 days, at which time a third-party attestation form will need to be provided. Self- Declaration is only good for 30 days and one time in a 12 month period.

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Third Party Insurance Coverage and Eligibility

Patients with third party insurance coverage are also eligible for the SFDP. Please provide your insurance card along with your SFDP application for a determination of your discount. COMC attempts to assess all patients for SFDP eligibility; however, for those patients that choose not to provide the information required to determine family size and income, even after being informed that they may qualify for discounts, are viewed as declining eligibility for the SFDP. These patients will be considered ineligible for sliding fee discounts.

Sliding Fee Discount Schedules

Patients will be charged on the Sliding Fee Discount Schedule (SFDS) based on their family size and income and no other factors. Patients will also be charged according to the SFDS for the type of service provided. These services are provided on separate SFDS and include Medical, Dental, Behavioral Health, Hospital, and Surgery.

Additional Charges May Be Incurred

Patients will be billed on a cost-plus basis for certain lab services and supplies. Examples include lab fees for Dentures, Partials, Crowns and Bridges as well as supply cost for contraceptive devices. Patient will be notified when additional charges will be incurred.

Payment Plans

Patients are expected to pay in full at the time of their visit. However, payment plans are available which allows patients to pay their outstanding balance over a period of time. Please speak with reception staff if you are interested in this program.

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The Sliding Fee Discount Program is retroactive for 30 days. All applications must be completed in FULL. Applications cannot be accepted without proper proof of income. Central Ozarks Medical Center is pleased to help meet your healthcare needs. We invite you to share this Discount Program information with others. If you have questions about this program, please speak to the reception staff.

Countable income includes:

- Taxable Wages
- Self-employment
- Retirement Benefits (including Social Security)
- Unemployment
- Alimony
- Interest, dividends, rents, and royalties

Non-Countable income includes:

- Child Support
- Non-cash benefits such as food stamps and housing subsidies
- Temporary assistance and other government cash assistance
- Social Security Disability (SSD)
- Supplemental Security Income (SSI)
- Veteran's benefits (VA Benefits) and disability (VA Disability)
- Workers Compensation payments
- Proceeds from life, accident, and health insurance
- Scholarships, awards, and fellowship grants used for education

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Sliding Fee Discount Program Application

Date: _____

Applicant's Full Name: _____
Last First Middle

Applicant's Address: _____
Street Address City State Zip

County: _____ Date of Birth: ____/____/____

Phone Number _____

Family Size:
Please list all members of your household whom you are financially responsible for, **including yourself**:

	Full Name of Household Member	Relationship	Date of Birth
1			
2			
3			
4			
5			
6			
7			
8			

Income:
Please list all sources of income generated by anyone counted in family size, regardless of marital status. **Please see Countable Income and Non-Countable income on the previous page**

	Type of Income	Amount of Income
1		
2		
3		
4		
5		
6		
7		
8		
	Total of all Rows	

If insured, please show reception a copy of your current insurance card.

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Please initial understanding of the following items:

_____I have read and understand the information contained in the "Sliding Fee Discount Program"
Initial Packet and agree to abide by these guidelines.

_____I understand that the expiration date for this information will be on_____per COMC policy.
Initial

_____I declare to information I have given is true and give Central Ozarks Medical Center (COMC)
Initial consent to investigate any information given in this application.

_____ Based on the number of people in my household and the income information I provided, I
Initial understand (1) the fee for each medical and behavioral health visit is $___ (2) the fee for each dental and surgical visit is dependent upon the service provided, and (3) this fee is due at the time of service unless I have been approved for a payment plan.

_____ I further understand that certain fees for labs and contraceptive supplies will result in
Initial additional charges.

Applicant's Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Federal Poverty Level: _____

Approved Discount Level: _____

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Self-Declaration of Income

I, _____, declare that I have been receiving income in the amount of $_____ per ☐Day ☐Week ☐Bi-weekly* ☐Semi-monthly* ☐Month

*Bi-Weekly pay is received every two weeks.

**Semi-Monthly pay is received twice a month (ex: Pay is received on the 1st and 15th of every month).

Amount paid per day: _____ x260 = Annual income of $_____

Amount paid Weekly: _____ x52 = Annual income of $_____

Amount paid Bi-Weekly: _____ x26 = Annual income of $_____

Amount paid Semi-Monthly: _____ x24 = Annual income of $_____

Amount paid Monthly: _____x12 = Annual income of $_____

if unemployed

I, _____, declare that I have no employment and do not have income of any kind.

I have no check stubs or other documentation to prove my earnings.

I acknowledge this self-declaration may only be completed once in a rolling 12 month period and the SFPD will only apply for 30 days

Patient Signature: _____

Date: _____

Office Use Only

I witness that this client has no documentation for proof of income:

Signature: _____

Date: _____

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Third Party Attestation Form

I,_____,

verify that, _____,

is currently unemployed and has had no income this year. I help provide for his/her living expenses; however, I am not responsible for his/her debts.

Signature: _____ Date: _____

Relationship: _____

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Central Ozarks Medical Centers
Sliding Fee Discount Schedule
Effective February 12, 2025

Sliding Fee Discount Program Eligibility is based solely on Family Size and Income

Office Fee Per Visit					
Medical	$30	$40	$60	$80	Full Fee
Behavioral Health	$30	$40	$60	$80	Full Fee
Dental (per procedure)	$30	*Tier 1 - $40 **Tier 2 - 30% of Charges	*Tier 1 - $60 **Tier 2 - 40% of Charges	*Tier 1 - $80 **Tier 2 - 50% of Charges	Full Fee
Hospital (per day)	$30	$40	$60	$80	Full Fee
Surgery	Tier 1 - $100.00 Tier 2 - $300.00 Tier 3 - $500.00	40% of Charges	60% of Charges	80% of Charges	Full Fee

Federal Poverty Guidelines (2025)					
Family Size	Level A (0-100% PFG)	Level B (101-133% PFG)	Level C (134-166% FPG)	Level D (167-200% FPG)	Level E (Above 200% FPG)
1	$0 - $ 15,650	$ 15,651 - $ 20,815	$ 20,816 - $ 25,979	$ 25,980 - $ 31,300	$ 31,301 and Above
2	$0 - $ 21,150	$ 21,151 - $ 28,130	$ 28,131 - $ 35,109	$ 35,110 - $ 42,300	$ 42,301 and Above
3	$0 - $ 26,650	$ 26,651 - $ 35,445	$ 35,446 - $ 44,239	$ 44,240 - $ 53,300	$ 53,301 and Above
4	$0 - $ 32,150	$ 32,151 - $ 42,760	$ 42,761 - $ 53,369	$ 53,370 - $ 64,300	$ 64,301 and Above
5	$0 - $ 37,650	$ 37,651 - $ 50,075	$ 50,076 - $ 62,499	$ 62,500 - $ 75,300	$ 75,301 and Above
6	$0 - $ 43,150	$ 43,151 - $ 57,390	$ 57,391 - $ 71,629	$ 71,630 - $ 86,300	$ 86,301 and Above
7	$0 - $ 48,650	$ 48,651 - $ 64,705	$ 64,706 - $ 80,759	$ 80,760 - $ 97,300	$ 97,301 and Above
8	$0 - $ 54,150	$ 54,151 - $ 72,020	$ 72,021 - $ 89,889	$ 89,890 - $ 108,300	$ 108,301 and Above
9 or more	Add $5,500 for each additional member	Add $7,315 for each additional member	Add $9,130 for each additional member	Add $11,000 for each additional member	

Tier 1 Services - Includes preventative care services such as new patient/recall exams, x-rays, polishing and fluoride

Tier 2 Services - Includes (but not limited to) restorative care services such as fillings, extractions, deep cleanings, or prosthetic devices (such as crowns, partials and dentures)

Revised 2/12/2025