



Sliding Fee Discount Instructions

Westbrook Health Services is a Comprehensive Community Behavioral Health Center who is able to offer a discount on certain services based on a household's income and size. Sliding fee calculations are determined by using an applicant's total household annual income and are based on the most recent Federal Poverty Guidelines (table attached) to determine your eligibility.

If you wish to qualify for the sliding fee, you must show proof of income for all family members/individuals (per IRS definition of dependents) living in your household or individuals for whom you are financially responsible for.

Applicants should provide a copy of the following documents, if applicable:

- Previous year's Federal Tax Return, W-2's or 1099's (Income will come from total income line)
- Most recent pay stubs spanning four weeks
- Social Security or Pension Income
- Public assistance award letters for each adult age 18 and over living in the household.
- Unemployment compensation

Your household discount will be assessed once per year. You must notify the Westbrook Registration department or Front Desk if your financial situation changes and reapply for the Sliding Fee discount, providing updated income documentation at this time.

PLEASE NOTE: You may still be responsible for the payment of some procedures and services; including copays, co-insurance, and/or deductibles. If you have any questions about your billing statement, please contact the Westbrook Health Services Billing Department at 1-304-485-1721, ext 881.

Return completed application and income documentation within 21 days to any Westbrook office location or mail to:

Westbrook Health Services
Attn: Registration Department
2121 7th Street,
Parkersburg, WV 26101

Westbrook Health Services

www.westbrookhealth.org

Phone: (304) 485-1721

Approved by QA 4/10/24

 **Crisis Hotline**
304-485-1725 or 1-800-579-5844



Sliding Fee Discount Application

Name: _____ Date of Birth: _____

Family Size (number of family members living in your household): _____

List name(s) and roles of family members/individuals (e.g., spouse, child, etc) living in your household or individuals for whom you are financially responsible for:

Address: _____

Phone: _____ Do you have insurance? YES ___ NO ___

If yes, Medical Plan Name: _____ Member #: _____

DISCLAIMER: I hereby certify that the above information is, to the best of my knowledge, true and correct. I further agree to notify Westbrook Health Services of any changes in this information within ten (10) days of such change.

I understand that I must re-qualify annually to maintain my eligibility.

I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government. Sliding Fee payment is due and payable at the time of service, or by way of patient statement. To maintain the discount, fees must be paid promptly. If you are unable to make payment at time of service, please contact the Westbrook Health Services Registration Department at 1-304-485-1721 ext 104 to make other payment arrangements.

Client Signature: _____ Date : _____

FOR INTERNAL USE ONLY

Annual Gross Income _____

Patient is eligible for sliding fee discount category _____

- Proof of income verified
 Patient refused to complete
 Patient does not qualify for sliding fee

Signature _____ Date _____

Verified by _____ Date _____



Sliding Fee Scale Based on 2024 Federal Register Poverty Guidelines

Family Size	Income Period	Category 1	Category 2	Category 3	Category 4	Category 5
Poverty Level		Up to 100%	100.01%-149.99%	150.00%-174.99%	175.00%-199.99%	200.00%+
Discount		100%	75%	50%	25%	0%
1	Annual	\$0 – \$15,060	\$15,061 – \$22,589	\$22,590 – \$26,354	\$26,355 – \$30,119	\$30,120 +
2	Annual	\$0 – \$20,440	\$20,441 – \$30,659	\$30,660 – \$35,769	\$35,770 – \$40,879	\$40,880 +
3	Annual	\$0 – \$25,820	\$25,821 – \$38,729	\$38,730 – \$45,184	\$45,185 – \$51,639	\$51,640 +
4	Annual	\$0 – \$31,200	\$31,201 – \$46,799	\$46,800 – \$54,599	\$54,600 – \$62,399	\$62,400 +
5	Annual	\$0 – \$36,580	\$36,581 – \$54,869	\$54,870 – \$64,014	\$64,015 – \$73,159	\$73,160+
6	Annual	\$0 – \$41,960	\$41,961 – \$62,939	\$62,940 – \$73,429	\$73,430 – \$83,919	\$83,920 +
7	Annual	\$0 – \$47,340	\$47,341 – \$71,009	\$71,010 – \$82,844	\$82,845 – \$94,679	\$94,680 +
8	Annual	\$0 – \$52,720	\$52,721 – \$79,079	\$79,080 – \$92,259	\$92,260 – \$105,439	\$105,440 +

For families/households with more than 8 persons, add \$5,380 for each additional person.