



Sliding Fee Discount Plan

Thunder Bay Community Health Service provides services to patients regardless of their ability to pay. For qualification, patients must provide a completed application and proof of income. Upon approval, the discount will be honored for one year from the date of application. Patients must reapply annually. Discounts are offered based on family size and income and could result in a minimum amount due of \$10.00 for medical or behavioral health services, \$30.00 for dental services, \$45.00 for optical lenses and frames and \$3.00 per prescription plus the cost of the medication. Assistance for insurance enrollment will be provided for eligible patients. The minimum payment is expected at the time of service.

Services Covered and Excluded

Professional Services: Discounts apply to all in office professional services. Services not eligible for discount include select medical supplies, upgrades to optical lenses and frames and a portion of the pharmacy medication. The minimum fee may not apply to all dental services.

Referred Care: Discounts do not apply to out of office referred care such as referrals to specialists, emergency room, and testing such as x-rays, CT scans, MRIs and pathology.

Lab: Discounts apply to in office charges for laboratory services. Lab tests referred to Quest Labs qualify for discount.



Thunder Bay
COMMUNITY HEALTH SERVICE, INC.

Discount Plan Application

Patient/Applicant Name: _____ Date of Birth: _____

Address: _____

(City)

(State)

(Zip)

Telephone: _____ Employer: _____

Spouse Dependents Under age 18	Relationship	Date of Birth	All Earnings Weekly Monthly or Annual

Proof of income is required for earnings listed

Do you have medical insurance? (Please list) _____

Do you have dental insurance? (Please list) _____

We assist the uninsured & underinsured obtain health insurance. Would you like us to contact you about this? Yes No

I certify that the information listed above is true and accurate and that I have no other income not listed. I understand that the information listed is subject to review of federal and/or state enforcement agencies or others as required.

Signature _____

Date _____

For Office Use Only

Approved Discount Rate _____ Effective Date _____ Recertification Date _____

Revised 06/2021