



2882 Holly Road
Corpus Christi, Texas 78415
Phone: (361)814-2001

Sliding Scale Program

The sliding fee program allows Coastal Bend Wellness Foundation (CBWF) patients who are uninsured or under-insured to receive healthcare services at a lower cost. We understand it's not always possible for patients to be covered by health insurance, or that insurance may have high deductibles. CBWF offers a sliding fee program to assist patients who may not qualify for public benefits and/or who are not able to afford the full cost of healthcare. An annual grant from the Bureau of Primary Health Care provides the resources which enable us to assist patients who may not otherwise be able to afford their medical care and medications.

The sliding fee program only applies to services provided at Coastal Bend Wellness and Medical (CBWM) facilities. Medication discounts apply only to prescriptions written by CBWM providers. Slide discounts cannot be used at other doctor offices, pharmacies or hospitals.

What services are offered?

- Medical
- Radiology
- Laboratory
- Pharmaceutical
- Behavioral Health

What is required to apply?

- Complete registration packet
- Provide proof of household income or financial assistance
- Household is defined as the applicant + spouse/significant other + their legal tax dependents

How often do I need to apply?

Patients will need to apply for the sliding fee program at least every year. The discounts will typically last 3, 6, or 12 months depending on the patient's unique financial situation. Patients renewing sliding scale eligibility will need to complete a new slide application packet and submit current proof of income before their discount expires. If the discount expires, the patient will have to pay the full charges until a new application packet is processed and approved.

Will I qualify?

See next page for income levels and fees.

COASTAL BEND WELLNESS FOUNDATION Inc.
Medical/Behavioral Health Sliding Fee Schedule

Based on 2024 HHS Federal Poverty Guidelines

Based on Annual Income

% of Poverty	A - 100%		B - 101-133%		C - 134-166%		D - 167-200%		E - Above 200%	
Family Size/Income	Above	Below	Above	Below	Above	Below	Above	Below	Above	
1	0	\$ 15,060	\$ 15,061	\$ 20,030	\$ 20,031	\$ 25,000	\$ 25,001	\$ 30,120	\$ 30,121	
2	0	\$ 20,440	\$ 20,441	\$ 27,185	\$ 27,186	\$ 33,930	\$ 33,931	\$ 40,880	\$ 40,881	
3	0	\$ 25,820	\$ 25,821	\$ 34,341	\$ 34,342	\$ 42,861	\$ 42,862	\$ 51,640	\$ 51,641	
4	0	\$ 31,200	\$ 31,201	\$ 41,496	\$ 41,497	\$ 51,792	\$ 51,793	\$ 62,400	\$ 62,401	
5	0	\$ 36,580	\$ 36,581	\$ 48,651	\$ 48,652	\$ 60,723	\$ 60,724	\$ 73,160	\$ 73,161	
6	0	\$ 41,960	\$ 41,961	\$ 55,807	\$ 55,808	\$ 69,654	\$ 69,655	\$ 83,920	\$ 83,921	
7	0	\$ 47,340	\$ 47,341	\$ 62,962	\$ 62,963	\$ 78,584	\$ 78,585	\$ 94,680	\$ 94,681	
8*	0	\$ 52,720	\$ 52,721	\$ 70,118	\$ 70,119	\$ 87,515	\$ 87,516	\$ 105,440	\$ 105,441	
	\$15 Nominal Charge		75% Discount		50% Discount		25% Discount		0% Discount	

* For each additional family member add

\$ 5,380

\$ 7,155

\$ 8,931

\$ 10,760

Based on Monthly Income

% of Poverty	A - 100%		B - 101-133%		C - 134-166%		D - 167-200%		E - Above 200%	
Family Size/Income	Above	Below	Above	Below	Above	Below	Above	Below	Above	
1	0	\$ 1,255	\$ 1,256	\$ 1,669	\$ 1,670	\$ 2,083	\$ 2,084	\$ 2,510	2,510.08	
2	0	\$ 1,703	\$ 1,704	\$ 2,265	\$ 2,267	\$ 2,828	\$ 2,829	\$ 3,407	3,406.75	
3	0	\$ 2,152	\$ 2,153	\$ 2,862	\$ 2,863	\$ 3,572	\$ 3,573	\$ 4,303	4,303.42	
4	0	\$ 2,600	\$ 2,601	\$ 3,458	\$ 3,459	\$ 4,316	\$ 4,317	\$ 5,200	5,200.08	
5	0	\$ 3,048	\$ 3,049	\$ 4,054	\$ 4,055	\$ 5,060	\$ 5,061	\$ 6,097	6,096.75	
6	0	\$ 3,497	\$ 3,498	\$ 4,651	\$ 4,652	\$ 5,804	\$ 5,806	\$ 6,993	6,993.42	
7	0	\$ 3,945	\$ 3,946	\$ 5,247	\$ 5,248	\$ 6,549	\$ 6,550	\$ 7,890	7,890.08	
8*	0	\$ 4,393	\$ 4,394	\$ 5,843	\$ 5,844	\$ 7,293	\$ 7,294	\$ 8,787	8,786.75	
	\$15 Nominal Charge		75% Discount		50% Discount		25% Discount		0% Discount	

* For each additional family member add

\$ 448

\$ 596

\$ 744

\$ 897

Patient pays a nominal \$15 fee for Office Visit regardless of income

NO ONE WILL BE DENIED SERVICES FOR INABILITY TO PAY, WE WILL SET UP PAYMENT PLAN WITH PATIENTS

Sliding Fee Program Application

1. Applicant Information

Which office do you go to: ☐ Main Office ☐ Kingsville Office

Is this your: ☐ 1st Time Application ☐ Renewal Application

Name of Responsible Party _____ Date of Birth _____

Address _____ SSN _____

City, State _____ Zip _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

Employer _____ Employer's Address _____

Do you have health insurance? ☐ yes ☐ no

Do you have pharmacy insurance? ☐ yes ☐ no

2. Household Members

Household = Spouse/Significant Other + Tax Dependents

Name (First Last)	Relationship	Date of Birth	SSN	Health Insurance Y or N	Pharmacy Insurance Y or N	Patient at CBWF Y or N	TAX Dependent Y or N

3. Household Income

Household = Spouse/Significant Other + Tax Dependents

Monthly/Annual Income	YOU (the Applicant)	Spouse/ Significant Other/	Children (over 18)	Others (Must be tax dependent)
NAME OF EMPLOYER AND EMPLOYER'S ADDRESS				
GROSS Wages, Salaries & Tips	\$	\$	\$	\$
Self-Employment or Stmt from Employer	\$	\$	\$	\$
Social Security & Disability	\$	\$	\$	\$
Supplemental Security Income	\$	\$	\$	\$
Workers Comp Benefits	\$	\$	\$	\$
Self- Declaration of Income	\$	\$	\$	\$
Child Support & Alimony	\$	\$	\$	\$
Savings, Interest Income, Pensions	\$	\$	\$	\$
Rental Property, Stocks, Dividends, Other				
TOTAL	\$	\$	\$	\$

4. Eligibility Information

Do you receive food stamps? ☐ yes ☐ no

Do you receive any public assistance? ☐ yes ☐ no

Did you file a tax return last year? ☐ yes ☐ no

Have you applied for Medicaid? ☐ yes ☐ no

Have you applied for Disability? ☐ yes ☐ no

Do you consider yourself homeless? ☐ yes ☐ no

Do you have health insurance? If so, what kind _____

How much is your Deductible? _____

Do you receive child support or alimony? ☐ yes ☐ no

5. Proof of Income Documents

Attach all items listed below to this

- ☐ **PHOTO ID** - a copy of your drivers license or other photo identification.
- ☐ **PAYSTUBS** - last/previous months paystubs of everyone working in the household OR a "Statement of Income from Employer" form from your employer with GROSS earnings for the previous month.
- ☐ **SELF-EMPLOYED** - complete/sign/date a "Self-Employed Statement" form **AND** make sure to include your Schedule C from your most recent tax return.
- ☐ **BENEFITS/INVESTMENTS/OTHER INCOME** - copies of any benefits checks and/or bank statements for all Investments, Social Security, Disability, Veterans Benefits, Unemployment, Child Support "Paid or Received", Alimony, TANF/AFDC, Military LES, Pensions, Interest payments, etc.
- ☐ **TAX RETURN** - all pages of your most recent tax return.
- ☐ **ZERO INCOME** - applicants with ZERO income must complete/sign/date a "Zero Income/Statement of Personal Assistance" form. If you are living off of savings, will need a copy of your bank or savings account statement.
- ☐ **RELEASE OF INFO/INCOME VERIFICATION** - if receiving public assistance or you have no/limited income, then complete/sign/date the "Release of Info/Income Verification from the DSS" form.

If the application is missing any of the above information or is not signed, it will be denied.

6. Patient Agreement

I certify that all statements contained herein are true and correct and subject to investigation. I authorize the release of employment records and other financial information to an agent of CBWF for sliding fee determination purposes. I understand the following:

- I am responsible for payment of all my copays at the time of service.
- I will notify CBWF of any changes to my income, household size or insurance status.
- I must renew my application to continue receiving the slide discount (at least annually—more if requested).
- Most routine services are covered under the slide discount. Some procedures, labs, injections and pharmaceuticals are discounted on a separate schedule.
- I understand that if I do not have pharmacy insurance, I may be eligible for pharmacy assistance programs. If eligible, my signature Authorizes CBWF to share medical, eligibility and financial information with pharmaceutical companies or their designees as required for eligibility or audit purposes.

Applicant's Signature: _____ Date: _____