Newport Hospital and Health Services

Newport Health Center

Express Care- 2026 Uninsured Sliding Fee Discount Program

What is the sliding fee discount program?
The Newport Health Center Express Care Sliding Fee Discount Program provides uninsured patients with access to Express Care services at a reduced cost.

How is eligibility determined?
All uninsured (self-pay) patients qualify for discounted self-pay pricing and are encouraged to apply. To receive discounted pricing, patients must complete a Sliding Fee Discount Application and provide a household income and family size attestation at each Express Care visit.

How much will you pay?
All uninsured (self-pay) patients receive a discounted self-pay rate for Express Care services. All payments are required prior to receiving care.

- The discounted rate for Express Care visits is $250.
- Based on your income and family size, you may qualify for an additional discount (see chart below).

Sliding Fee Schedule Based on 2026 Federal Poverty Levels (FPL)

Family Size	Household Income	Household Income	Household Income	Household Income	Household Income
FPL	100% or less	101% to 133%	134% to 166%	167% to 200%	201% and up
1	up to $15,960	$15,961 to $21,227	$21,228 to $26,494	$26,495 to $31,920	$31,920 and up
2	up to $21,640	$21,641 to $28,871	$28,782 to $35,922	$35,293 to $43,280	$43,281 and up
3	up to $27, 320	$27,321 to $36,336	$36,337 to $45,351	$45,352 to $54,640	$54,641 and up
4	up to $33,000	$33,001 to $43,890	$43,891 to $54,780	$54,781 to $66,000	$66,001 and up
5	up to $38,680	$38,681 to $51,444	$51,445 to $64,209	$64,210 to $77,360	$77,361 and up
6	up to $44,360	$44,361 to $58,999	$59,000 to $73,638	$73,639 to $88,720	$88,721 and up
7	up to $50,040	$50,041 to $66,553	$66,554 to $83,066	$83,067 to $100,080	$100,081 and up
8	up to $55,720	$55,721 to $74,108	$74,109 to $92,495	$92,496 to $111,440	$111,441 and up
Additional Discount	**84%**	**75%**	**50%**	**25%**	**0%**
Co-Pay	**$40.00**	**$62.50**	**$125.00**	**$187.50**	**$250.00**

What does the Sliding Fee Discount apply to?
The Sliding Fee Discount applies **only** to Newport Health Center Express Care office visits.

The discount **does not** apply to any services performed outside of the Express Care visit, even when ordered during your visit (Example: labs, x-rays, prescriptions, etc.).

The Sliding Fee Discount Program is separate from the Newport Hospital & Health Services Financial Assistance Program. Financial Assistance does not apply to Express Care office visits.

Please call Patient Financial Services at 509.447.9351 if you have any questions – we're happy to help!

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Express Care – Sliding Fee Discount Application

NOTE: This application applies to the Uninsured Sliding Fee Discount program at Newport Health Center and is valid for Express Care services ONLY. Labs, X-rays, and any other additional testing furnished outside of Express Care are not included, even if ordered during an Express Care visit.

1. PATIENT INFORMATION

NAME: _____ BIRTHDATE: __ __/__ __/_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: (_____) _____ - _____

MARITAL STATUS: _____ ALTERNATIVE CONTACT PHONE: (_____) _____ - _____

2. MEMBERS OF HOUSEHOLD (please include yourself)

	Name	Birthdate	Relationship to Patient
1.			
2.			
3.			
4.			
5.			
6.			

3. INCOME AND EMPLOYMENT

Are you currently employed? ☐ Yes ☐ No (choose one)

TOTAL HOUSEHOLD INCOME $_____ ☐ Per Month ☐ Annual (choose one)

Source(s) of household income: _____

By signing below, I certify the information provided on this form is true and correct to the best of my knowledge. If the information provided on this form is false or information was deliberately withheld to become eligible, I acknowledge I will be responsible for the total charges incurred. I also understand that this discount is only good for the date of service for which I am being seen and that is dated on this application. I understand that I must re-attest for each visit. I acknowledge that this sliding scale is limited to Newport Health Center Express Care visits and is separate from the Newport Hospital and Health Services Financial Assistance Program.

_____ _____

APPLICANT'S SIGNATURE **DATE**

FOR OFFICE USE ONLY:

Qualifying Sliding Fee Discount _____%

Application is Approved: _____ Denied: _____

Total owing balance: $_____ Date_____

Authorized By:_____ Date_____