Thundermist
HEALTH CENTER

Hello,

Thundermist provides care to all patients regardless of their ability to pay. We are writing to remind you about Thundermist's Sliding Fee Discount Program, which is available to all eligible patients, with or without insurance. The program ensures all patients who are insured, uninsured, or underinsured can receive care without a financial barrier.

To find out if you qualify for the program, please fill out the Eligibility Form attached to this message, sign it electronically, and email it back to us/submit it. If electing to email, please send to medicalrecords@thundermisthealth.org.

While we are required to let you know about the Program, you do not have to enroll if you do not want to. If you do not want to, simply click that box on the form that says you do not want to enroll, sign it electronically and email it back to us/submit it. Please note: Even if you have insurance, you may qualify for discounts to certain co-pays and other fees.

If you need additional help in applying for Sliding Fee Discount Program or have more questions, please call us at 401-767-4100. We'll be happy to help you. You may also find additional information on our website.

Best Regards,

Thundermist Health Center

WOONSOCKET
Medical
450 Clinton St.
Woonsocket, RI 02895

Phone: 401-767-4100
Fax: 401-235-6896

Dental & WIC
25 John A. Cummings Way
Woonsocket, RI 02895

Dental Phone: 401-767-4161
Dental Fax: 401-767-5441

WIC Phone: 401-767-4109
WIC Fax: 401-235-6883

WEST WARWICK
Medical
186 Providence St.
West Warwick, RI 02893

Phone: 401-615-2800
Fax: 401-615-2805

Dental
5 Washington St.
West Warwick, RI 02893

Phone: 401-615-2804
Fax: 401-352-6248

SOUTH COUNTY
Medical & Dental
1 River St.
Wakefield, RI 02879

Phone: 401-783-0523
Fax: 401-783-9448

Dental Phone: 401-783-5646
Dental Fax: 401-284-2081

Pediatrics
360 Kingstown Rd.
Narragansett, RI 02882
Phone: 401-789-6492
Fax: 401-783-9448

Office Use Only: [check box] is this for a phase II dental service? Y N

If yes – staff required to collect income verification.

Thundermist HEALTH CENTER

Sliding Fee Discount Program Form

We will care for you even if you cannot pay. You may be eligible for discounts based on income and family size. Discounts are available, even if you have insurance.

Patient Name: _____ Patient Date of Birth: _____

1. Including yourself, what is the size of your family? (Use definition below)
   _____
2. What is the total annual income of those included in your family in Question #1?

   $ _____ ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
3. Please select 1 (one) option below:

☐ I certify the information entered above is correct to the best of my knowledge. I agree to inform Thundermist if my family size or income changes. I understand changes to my family size or income may change if I am eligible for the Thundermist Sliding Fee Discount Program.

☐ I do not want to participate in the Thundermist Sliding Fee Discount Program.

Print Responsible Party Name (If other than Patient) Date

Responsible Party Signature Date

*Family Size: Include yourself and other people related by birth, marriage, or adoption who live together. Family also includes unrelated people who live in the same household and are supported by or supporting a member of the family. Foster children are not included in Family Size.