COMMUNITY HEALTH & WELLNESS PARTNERS OF LOGAN COUNTY

NO INSURANCE?

HIGH DEDUCTIBLE OR CO-PAY?

FINANCIAL CONCERNS?

Ask about our SLIDING FEE SCALE!

- Application AND Proof of Income REQUIRED

Each application will be determined eligible by comparing the household income and family size.

General office and behavioral health visits, procedures, preventative exams, vaccines			
Household Size	**Gross Household Monthly Income Less Than**	**Gross Household Monthly Income Between**	**Gross Household Monthly Income Greater Than**
1	$1,005	$991-$2,010	$2,011
2	$1,353	$1,354-$2,706	$2,707
3	$1,701	$1,702-$3,403	$3,404
4	$2,050	$2,051-$4,100	$4,101
5	$2,398	$2,399-$4,796	$4,797
6	$2,746	$2,747-$5,493	$5,494
Cost Per Visit/Level	Full Discount*	$35(B), $45(C), $55(D), $65E	Do Not Qualify (F)

**Nominal Fee May Apply*

***Final rate to be determined by submitted documentation, CHWPLC staff and current sliding fee scale*

Initial Application_____ Renewal_____

COMMUNITY HEALTH & WELLNESS PARTNERS OF LOGAN COUNTY

Sliding Fee Application

Applicant's Name _____ Today's Date _____

Address _____

City_____ State _____ Zip _____

Phone 1 _____ Phone 2_____

Before approval can be given the following MUST be received at time of or within 30 days of application.

- Current photo ID along with One Proof of income for applicant and other household members over age 19.
- Proof of Identity for all household dependents listed under age of 19.

Proof of Income (Copy of 2 or more checks/paystubs, recent tax return or W-2, public assistance or Social Security letter, Bank Statements, Child Support, Alimony, Unemployment, Medical Assistance or Dept. of Social Services Certification Letter **(Include all household income)**

- Must be current within 30 days of application
- If unable to provide documentation of Income (Complete Declaration of Income Form)
- Note: Total Gross Income will be calculated to determine approval

List yourself on Line 1, spouse or significant other on Line 2 and all dependents under the age of 19 on Lines 3-7.

Household Members	Name(s)	DOB MM/DD/YYYY	Monthly Gross Income	Student (S)	Employed (E)	Other (O)	Office Use Only Patient/Chart #
1 (self)		/ /					
2		/ /					
	Dependents under age 19						
3		/ /					
4		/ /					
5		/ /					
6		/ /					
		Total					

Documentation of No Income: If you report $0 income, please explain below how you are surviving without income:

_____

_____

_____

_____ _____

Patient's Signature CHWPLC Witness

Certification: I certify that the household size and income information shown above is correct. **I understand that documentation supporting my household financial position is required before my discount can be approved and that I must provide this information within 30 days or prior to my next visit if sooner.**

I understand that I must update this information if my situation changes and that a new Sliding Fee Application must be completed at least every twelve (12) months. I have received information explaining the program and I understand and agree to abide by the terms. I understand that if I am a self-pay patient**; I will be responsible to pay at least a minimum of $25 for healthcare services**. If an unpaid balance exists on my account after applying my sliding fee discount, I agree to make payment arrangements and honor the terms. I understand that if I am unable to make a payment in any given month, I must contact the Billing Office prior to the due date to discuss my need to modify my payment arrangement.

_____ _____ _____

Patient Name (print) Signature or Patient or Guarantor Date of Signature

FOR CHWPLC OFFICE USE ONLY

Application Reviewed By:	**Date:**
Documentation Received By:	**Date:**
Sliding Fee Approval Level (A-E):	**Date:**
Signature:	

COMMUNITY HEALTH & WELLNESS PARTNERS OF LOGAN COUNTY

WAIVER of Sliding Fee Scale Discount

DO NOT sign below if you wish to be considered for a discount. Signing below will **void** your Sliding Fee Application.

I choose not to complete the Sliding Scale Application at this time. I am waiving my right to any discount to which I may otherwise be entitled. I understand that I will be responsible for full payment of all charges at the time of service.

_____	_____	_____
Patient Name (print)	Signature or Patient or Guarantor	Date of Signature