



Application for Sliding Scale Fee Program

APPLICANT INFORMATION

Applicant's Last Name _____ First Name _____ MI _____

Social Security Number (Tax ID #) _____ - _____ - _____ Date of Birth _____

Drivers License or State ID # _____ State _____ Sex: Male Female

Address _____

City _____ County _____ State _____ Zip _____

Day Phone () _____ Alternate Phone () _____

Marital Status: Single Married Separated Divorced Widowed

If married provide spouse information.

Spouse Last Name _____ First Name _____ MI _____

Social Security Number (Tax ID #) _____ - _____ - _____ Date of Birth _____

Drivers License or State ID # _____ State _____ Sex: Male Female

Responsible party information if different from applicant or spouse

Applicant's Last Name _____ First Name _____ MI _____

Social Security Number (Tax ID #) _____ - _____ - _____ Date of Birth _____

Drivers License or State ID # _____ State _____ Sex: Male Female



MEDICARE OR OTHER HEALTH INSURANCE COVERAGE

Is anyone applying for Sliding Scale Fee benefits covered by Medicare or any other health insurance? (Example: applicant, spouse or dependents) Yes No

If yes, complete the following:

| Name of Person(s) covered | Insurance Company | Policy Identification # |
|---------------------------|-------------------|-------------------------|
| | | |
| | | |
| | | |
| | | |

If applicant(s) is covered by Medicare do they receive Pharmacy benefits? Yes No

Does applicant have a Medicare HMO or Secondary Insurance along with their Medicare coverage? Yes No If Yes, which of the following?

Check one: AARP BCBS Partners United Health Care CIGNA

Medicare Complete Evercare Other _____

OTHER BENEFIT INFORMATION

Has application been made for Medicaid in the past six months? Yes No

If yes, is the applicant eligible? Yes No Pending

If No, attach a copy of the denial letter.

Has application been made for SSI benefits in the past six months? Yes No

If yes, is the applicant eligible for SSI Benefits? Yes No Pending

Is the applicant receiving services through any other program? Yes No

If yes, please specify. _____



HOUSEHOLD INCOME

List all persons in the household who are currently working. If self employed, please provide a copy of the most current Federal Income Tax return.

| Name | Employer / Occupation | Work Phone # |
|------|-----------------------|--------------|
| | | |
| | | |
| | | |
| | | |

Other Income (per month):

- Child Support \$ _____
- Unemployment \$ _____
 Begin _____ End _____
- Workman's Compensation \$ _____
 Begin _____ End _____
- Disability Benefits / Including SSI \$ _____
- Work First Family Assistance \$ _____
- Insurance Payments received \$ _____
- Retirement / Pension Benefits \$ _____
- Social Security Benefits \$ _____
- Veterans Benefits \$ _____
- Trust Fund Income \$ _____

Additional Income:

List all income from alimony, boarders, cash contributions from relatives or other persons, property rentals, mortgage income, interest, dividends, royalties, savings accounts, stocks, bonds, insurance or other sources.

Source: _____ Total per month: \$ _____

Source: _____ Total per month: \$ _____

Source: _____ Total per month: \$ _____

Source: _____ Total per month: \$ _____



C.W. Williams
COMMUNITY HEALTH CENTER

Generations of Care

If you report no income, have you applied for public assistance? Yes No

If Yes, what is the status? _____

If you report no income, please explain how food and shelter is provided for the applicant(s).

Are you new to the Sliding Scale Fee Program? Yes No

How did you hear about the program? _____



DOCUMENTS THAT MUST BE TURNED IN WITH THE SLIDING SCALE APPLICATION

- Proof of Identification** - Documents must be turned in that contain both the name and date of birth of the applicant(s). Documents from the list below may be used.
 - Adoption Records
 - Birth Certificate
 - Driver's License
 - Employment ID card with name and photo
 - Marriage License
 - Military Service Papers
 - Passport
 - School ID card with name and photo
 - School Records
 - State ID

- Proof of Income** - The following documents may be used:
 - A signed and dated Wage and Verification Form (Forms available with Front Desk staff)
 - Copies of two most recent pay stubs for each employed adult in the applicant(s) household
 - If a person or organization is assisting you financially, provide a notarized statement to that effect.
 - If between January 1st and April 15th, a copy of the most recent W-2 forms for each employed adult
 - If the applicant is self-employed, the most recent signed and dated Federal Income Tax forms

- Additional Income** – Adult family members must provide copies of award letters from the following sources:
 - Child Support Payments
 - Life Insurance Payments
 - Retirement or Pension Fund
 - Social Security Benefits
 - SSI Income
 - Supplemental Security
 - Unemployment Payments
 - Veteran's Benefits
 - Work First Family Assistance
 - Workman's Compensation
 - Other

- Proof of Dependents**
 - Please provide the following for all dependent children:
 - Birth Certificate
 - Current Medicaid card with the applicant's name listed on the card as the responsible party
 - Most recent tax form showing that you claim the person as a dependent
 - Please provide the following for all other dependents:
 - Most recent tax form showing that you claim the person as a dependent

- Medicare Eligibility**
 - Medicare Card
 - Proof of medical / pharmacy insurance ineligibility



Sliding Scale Fee Program Agreement

I certify that the income and other registration information on this application form for Sliding Scale Fee (SSF) benefits are true and complete. I further understand that my health center records are subject to federal audits. If it is determined that I have falsified any information regarding statements contained in this application, I could be subject to penalties under Federal or State Law, and would result in denial/dismissal of SSF eligibility. I understand that I must inform C.W. Williams Community Health Center (CWWCHC) of any changes in my financial status within ten business days of said change. *Initial

I authorize the release to CWWCHC of all data, records, information by insurance companies, providers of medical care, financial institutions, federal, state, or local governmental agencies, and any other persons, agencies or organizations necessary for CWWCHC's pursuit of third party reimbursement or verification of statements provided by me or any other persons whose income and resources will be considered in this application. I understand that this signed application serves as written authorization for any of the above persons, agencies or organizations to release the information required.

I understand that CWWCHC regulations must be followed regarding use of other third party coverage before CWWCHC can pay for any services. I agree to file an insurance claim for any service that insurance may cover.

I understand that SSF only covers medical services provided by CWWCHC physicians.

I understand that the CWWCHC Pharmacy can only fill prescriptions for patients eligible for SSF that are written by CWWCHC physicians.

Name of Applicant (Please Print)

Signature of Applicant

Date

Name of Spouse (Please Print)

Signature of Spouse

Date

Name of Responsible Party (Please Print)

Signature of Responsible Party

Date