COMMUNITY HEALTH & WELLNESS PARTNERS
Care... To Live Life Fully

Initial Application or Renewal:

Sliding Fee Application

A Sliding Fee Scale is available. Discounts are based on income and family size.
If you do not wish to be considered for a discount, please skip to the WAIVER section.

Applicant's Name_____ Today's Date _____

Address _____ Date of Birth _____

City_____ State _____ Zip _____ Phone _____

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 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 3-6

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					

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 eligible for the sliding fee discount**; I will be responsible to pay at least a minimum nominal fee 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

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128
chwplc.org

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

_____

_____

_____ _____

Patient's Signature CHWPLC Witness

Because we are partially funded by a federal grant, we are asked to collect income information. Please determine the number of persons in your household and check your annual (yearly) income range. This information is for generalized reporting regarding the health center, **NO PERSONAL INFORMATION IS SHARED.**

NUMBER OF PEOPLE IN YOUR HOUSEHOLD: _____

Range 1	Range 2	Range 3	Range 4	Range 5	Range 6
◯ $0 to $15,000	◯ $15,001 to $30,000	◯ $30,001 to $45,000	◯ $45,001 to $60,000	◯ $60,001 to $75.000	◯ $75,001+

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. Even if you have insurance, you may still qualify for an additional discount if you provide your household income information and provide applicable documentation as stated on the 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

FOR CHWPLC OFFICE USE ONLY

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

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To see if you qualify, review the following information…
Find your household size and monthly income on the chart

Step 1. Circle Household Size
Step 2. Circle MONTHLY Gross Income Range (on same line) for household size you selected
Step 3. If your circle is in the middle two columns you qualify for a sliding fee discount **

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	$1,133	$1,134-$2,266	$2,267
2	$1,526	$1,527-$3,052	$2,905
3	$1,919	$1,920-$3,838	$3,839
4	$2,313	$2,314,$4,626	$4,627
5	$2,706	$2,707-$5,412	$5,413
6	$3,099	$3,100-$6,198	$6,199
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*

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