Community Health Care Systems, Inc.
Sliding Fee Application

General Guidelines:

The sliding fee program is made possible through federal grant funding. Community Health Care System's ability to continue this program relies on the participant's adherence to the guidelines.

1. To apply for the sliding fee discount, proof of household size and household income is required and will need to be updated **annually or as otherwise noted.** Acceptable proof of income includes: *most recent paycheck stubs (4), a current year w-2 form, or a summary notification that you have applied for assistance through DFCS, and a current tax return. Notarized statements of income will be accepted in unique situations. Applications cannot be approved without proof of income.*
2. Minors cannot apply for the sliding fee discount.
3. The participant's fee for services is determined by household income and number of persons living in the household. The minimum office visit fee program participant is $25.00 for each office visit. **Failure to pay the required fees will result in termination from the program.**
4. The sliding fee discount program also provides assistance for purchasing prescriptions. The pharmacy program will be explained upon completion of the application and acceptance into the program.
5. **Participants with insurance providing any type of prescription benefit are not eligible for participation in the pharmacy discount program**.

Patient's Name _____ **Date of Birth** _____

Household History

Household Member	Minor	Employed	Other Income (Child Support/SSI, etc.)	
_____	__Y__N	__Y__N	__Y__N	If yes, please list. _____
_____	__Y__N	__Y__N	__Y__N	If yes, please list. _____
_____	__Y__N	__Y__N	__Y__N	If yes, please list. _____
_____	__Y__N	__Y__N	__Y__N	If yes, please list. _____
_____	__Y__N	__Y__N	__Y__N	If yes, please list. _____

Did you file federal taxes for previous year? __Y__N (if yes, provide a copy or complete form 4506-T)

Have you applied for Medicaid within last 2 years? __Y__N (If yes, provide copy of denial letter. If no, may benefit to re-apply)

I do hereby swear or affirm that to the best of my knowledge the information that I have provided on this form is true and accurate. I will notify Community Health Care Systems if there is any change in my income. I also understand and agree to the terms of this agreement and realize that failure to abide by these terms will terminate my ability to participate in this program. I also acknowledge receipt of the sliding fee guidelines for my records.

Signature of Applicant: _____ **Date:** _____

Approved by: _____ **Date:** _____

Percentage Approved: _____ 0% _____ 25% _____50% _____75% **Income: _____ Meets _____ Exceeds**