COMMUNITY HEALTH CENTER OF CENTRAL WYOMING
We are your health

Slide Application

To apply:

Call 307-233-6000 and press option #2 to request an application.

Apply online at http://www.CHCCW.org.
Navigate to the "Financial Services" tab and click on "Sliding Fee Application".

Stop by any Community Health center location for a paper application.

- Documentation of proof of income is required. The application **will not be processed** until **all** necessary information is received.
- The Casper facility is the only location that can accommodate a face-to-face appointment. Please call 307-233-6000 if you wish to schedule a slide appointment.
- Once the application is complete, return to us via fax (307-233-6089), email (slide@chccw.org), or drop off the paper application to any CHCCW location. **Please include all required documentation with your application.**
- The application will be processed within 10 business days of receipt. Incomplete applications or applications missing the required documentation will be denied until the necessary information has been received.
- All applicants will receive a letter with the determination of the application:

  Approved The letter will state the level of slide the application qualified for, effective and end dates, and include an explanation of benefits.

  Denied The letter will state the reason for the denial. You may reapply anytime you obtain the proper documentation or if there is a change in household income and/or family size.

Please keep the letter for future verification. **It is recommended to make note of the end date and reapply 30 days prior to avoid any lapse in slide coverage.**

- If you have not been contacted within the 10 business days, please call 307-233-6000, options 2 for status updates and/or verification.

- **All CHCCW patients are expected to pay at the time of service**.

  Accounts will be reviewed during the application process to verify they are in good standing.

  If you are unable to make your payment at the time of service, please contact the billing departing to make payment arrangements within 10 days.

MRN # _____

Applicant Information

Applicant name: _____ DOB: _____

Mailing Address: _____

City:_____ State _____ Zip: _____

Phone: _____ email: _____

How would you like us to contact you? _____ Phone _____ Email _____ Mail

Applying for the sliding fee scale allows Community Health Centers to provide services at a discounted rate only at our locations. The approval is based upon the Federal Poverty Guidelines, family size, and household income.

2024 Federal Poverty Levels Effective: January 18, 2024				
	A	B	C	D
Family Size	**0-100% of Federal Poverty Level**	**101-133% of Federal Poverty Level**	**134-166% of Federal Poverty Level**	**167-200% of Federal Poverty Level**
1	$ - $15,060.00	$15,060.01 $20,029.80	$20,029.81 $24,999.60	$24,999.61 $30,120.00
2	$ - $20,440.00	$20,440.01 $27,185.20	$27,185.21 $33,930.40	$33,930.41 $40,880.00
3	$ - $25,820.00	$25,820.01 $34,340.60	$34,340.61 $42,861.20	$42,861.21 $51,640.00
4	$ - $31,200.00	$31,200.01 $41,496.00	$41,496.01 $51,792.00	$51,792.01 $62,400.00
5	$ - $36,580.00	$36,580.01 $48,651.40	$48,651.41 $60,722.80	$60,722.81 $73,160.00
6	$ - $41,960.00	$41,960.01 $55,806.80	$55,806.81 $69,653.60	$69,653.61 $83,920.00
7	$ - $47,340.00	$47,340.01 $62,962.20	$62,962.21 $78,584.40	$78,584.41 $94,680.00

MRN # _____

Please complete the table below to include all individuals who may be claimed on the guarantor's annual tax return or individuals who share a gross income.

DATE LAST SEEN AT ANY CHCCW LOCATION OR DEPARTMENT _____

Appointments 10 days prior to approval date will be included in slide discount.

Name: First, middle, last	Relationship to box one	Date of birth	Sex at birth M/F	Social security number	Income source: i.e., Job, SSDI, unemployment	Total annual income	Internal use ONLY
1	**Self**						
2							
3							
4							
5							
6							
7							

1. **Please include copies of proof of income with this page to complete your application process.**
2. **If you have not had any income in the last 30 days, check the box below, and complete the next page.**

☐ **I am self-attesting as I have had no income for the past 30 days.**

I, the undersigned, have completed this application for CHCCW's sliding fee eligibility and confirm that this information is true and correct, to the best of my knowledge. I further understand that should my economic situation change; I am solely responsible to report the change upon my next visit. All information I provided with in this application, including a self-attestation statement if applicable is truthful, correct and is subject to confirmation by CHCCW. Any false statement or perceived attempt to deceive may result in a denial of the sliding fee benefits and the balance associated with it would be my responsibility.

Signed: _____ Date: _____

MRN# _____

SELF-ATTESTATION WITH NO INCOME

Community Health Center of Central Wyoming allows for patients to self-attest if they are currently unemployed and/or do not receive income at the time of service. Please fill out the information below to support this Self-Attestation. Failure to answer these questions may result in your application being denied.

1. How long have you been unemployed and/or been without any income? _____
   _____

2. What is your current status? ____ Looking for work _____ Applying for disability _____ Temporarily laid-off
   _____ Full-time Student _____ Other: (Please Explain) _____
   _____
   _____
   _____

3. Do you receive benefits or assistance with living expenses for any of the following? (Check all that apply)

____ Rent/Housing	____ Energy Assistance	____ Food Stamps (SNAP)	____ Unemployment
____ Friends/Family	____ TANF	____ Churches	____ Non-profit Organization
____ Child Support	____ Student Loans	____ Shelters	____ Other: _____

4. If you do not receive assistance from any of the above, how are you paying for basic living expenses? (Ex: Rent, utilities, food, clothing, etc.) _____
   _____
   _____
   _____

I, _____, attest that I currently have no income to report at this time of service for care at CHCCW. I further understand that should my economic situation change; I am solely responsible to report that upon my next visit. All information I provided within this application, including my self-attestation statement is truthful, correct and is subject to confirmation by CHCCW. Any false statement or perceived attempt to deceive may result in a denial for sliding fee benefits and any patient balance will be my responsibility.

Signed: _____ Date: _____