COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING

We are your ***health***

SLIDING FEE SCALE

Thank you for your interest in Community Health Center's Sliding Fee Program. This program is intended to help those under the 200% FPL, defer some of the out-of-pocket medical expenses for individuals with or without insurance. To qualify we require that you provide documentation of your household income and complete the attached application. If you wish to apply for a sliding fee discount please follow the directions below, fill out the attached application in its entirety and provide the requested documentation. You may qualify for fee reductions retroactively prior to the date your application is received if the proper documentation is **provided within 10 days**.

Step 1. Fill out the Sliding Fee Application, you must include all household members and sign your application.

Step 2. Provide proof of your income. Please provide the following documents for each member of your household (related and unrelated) over the age of 18, to show household income:

- **Income Tax Return**- A signed copy of the most recent tax return showing Adjusted Gross Income.
- **Paycheck stubs**- Most recent pay stubs(s) indicating gross pay (Most recent 30-day period of work).
- **Agency Letter**- A letter from the Social Security Administration, Veterans Administration or Social Service Agency (i.e., AFDC, Food Stamps, or WIC) indicating income level.
- **Unemployment Verification**- Paperwork from the Employment Securities Commission (ESC), proving unemployment status and the amount of unemployment compensation being received.
- **Court Documents**- Official documents citing child support or alimony as awarded by a judge accompanied by a statement of child support enforcement stating amount received.
    - In the situation when a patient seeks services and identifies themselves as being separated from their spouse, legal documentation such as a legal separation agreement or divorce filing will be requested from the patient; but not required if self-declared.
- **Official Paperwork**- Paperwork documenting retirement, disability, and SSI benefits.
- **Employer Letter**- For those not receiving an actual paycheck, a letter from the patient's employer detailing current gross income and frequency of pay periods may be accepted. Contact information must be provided so that the information can be verified. (Preferably on business letterhead).
- **For patient with no job or other income source**- A letter from an agency, friend, relative or past employer who knows the situation and is not living with the applicant. The letter must include the writer's name and address (phone number if available) as well as a current or recent date (i.e., not from 2003).
- **Self-declaration**- is acceptable if no other information can be provided, the self-attestation form is to be completed.
- **Minors**- Minors applying for SFDS may declare as a separate household when seeking services for reproductive health. To include but not limited to, STD testing, pregnancy, birth control, etc.

Step 3. **Return your Sliding Fee Application along with the supporting documentation using one of the ways listed below:**

- Drop off at any of our Community Health Center of Central Wyoming clinics
- Mail it to CHCCW Billing Department, 5000 Blackmore Road, Casper, WY 82609
- E-mail it to slide@chccw.org
- Fax it to 307.233.6089
- Complete using our online form

Step 4. **Patient notification of Qualification** Your application will be processed, and you will receive a letter or email (based on the answer to the question on the slide fee application) explaining whether you qualify based on your application. If additional documentation is needed, we will contact you by telephone, mail, or email. Please allow up to 10 days for processing your application after it is received.

If it is determined that you do not qualify for our sliding fee program you will be responsible for any accrued charges If it is determined that you do qualify for our sliding fee program a credit will be given if you have overpaid for your clinic visit and have no other outstanding bills or past bad debt to CHCCW.

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SLIDING FEE SCALE APPLICATION

This information is STRICTLY CONFIDENTIAL, and your name will never be disclosed in any reports. Please complete this form, listing everyone in your household, and their annual income.

Applicant Name:____DOB: _________________

Address: ________________________________ City:___________________ State:__________ Zip:_________

Phone: _______________________ Email: ____

How would you like us to contact you? _____Phone ______Email ______ Mail

If you do not have any income from the past month and are going to self-attest today, please mark the box, fill out household assessment below and the statement attached.

- ☐ I am self-attesting (continue to Self-Attestation with No Income Statement)
- ☐ I am applying for the sliding fee and proving income verification (complete the below form, listing everyone in your household)

Name (First Name, Middle Name, Last Name	Relation to #1	Date of Birth	Sex at Birth (M, F)	Social Security Number	Total Monthly Income	Total Annual Income	Source (Job, SSDI, Unemployment Benefits)
1	Self						
2							
3							
4							
5							
6							
7							

I, the undersigned, have completed this application for 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 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 the balance associated with it would be my responsibility.

Signed:____Date:________________

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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: ______________