REQUIRED SLIDING SCALE INFORMATION

INCOME TAX RETURN
(IF NOT PROFESSIONALLY PREPARED, MUST INCLUDE W-2 FORMS)

VALID PHOTO ID

SOCIAL SECURITY CARD OR BIRTH CERTIFICATE

30 DAYS' WORTH OF CHECK STUBS
(CONSECUTIVE AND DATED WITHIN THE LAST 45 DAYS)

SOCIAL SECURITY
(LETTER SHOWING THE AMOUNT OR 1099)

PENSION
(LETTER SHOWING THE AMOUNT OR 1099)

CHILD SUPPORT OR ALIMONY

UTILITY BILL WITH NAME AND PHYSICAL ADDRESS

PLEASE COMPLETE ALL FORMS IN BLACK INK

REVISED 02/12/2020

Camden Family Health
Sliding Fee Scale Application

Name:			
Physical Address:			
Mailing Address:			
City:		State:	Zip:
Telephone:	( )	Cell Phone: ( )	
Sex:	Male Female	Marital Status: S M D W Separated	
Social Security #:		Birth Date:	
Head of Household:			
Email Address:			
Medical Coverage (Please bring insurance cards)			
Health Insurance:			
WV Medicaid #:			
Medicare #:		UMWA#:	
Other:			
Employer:	---		

Name	Relationship	Birth Date	Social Security #
SELF – INFORMATION	*ABOVE*		

ADMINISTRATIVE USE ONLY:

Income BreakDown

Source	Amount

Total monthly GROSS income: _____

FY 20___ 1040 EZ A Sch: A C EIC SE Total Income: $

or Self-employed AGI: $

By my signature, and to the best of my knowledge, I certify that the information above is true.

Applicant's Signature: X _____

Date: X _____

Reviewed By: _____

Date: _____

Based on the family size and the income information provided, this patient/family is hereby assigned a pay status of: _____

___ Pay stubs
___ Pay letters
___ Court Doc'n
___ 1040
___ A- Valid WV ID
___ A- Military ID
___ A- WV Voter Reg'n
___ W2'S
___ A- WV Utility bill
___ A- WV Real Estate taxes
___ B-Valid Social Security
___ A- WV Mail in Name
___ SSA letter (6-mo)
___ DHHR letter (6-mo)
___ B-Birth Certificate (w/seal)

Camden Family Health
Statement of Understanding

The information I have given concerning my family's gross monthly/annual income from all sources is true, accurate, and complete to the best of my knowledge. I have given this information concerning my financial situation and my means/ability to pay, for the purpose of procuring, for my own and my family's benefit, the discount qualified for under the "Sliding Fee Discount Program" guidelines. This discount will apply to all accounts in my household, which is understood to mean only those individuals who are claimed on my tax return. I understand that this discount applies only to accounts I have with Camden on Gauley Medical Center, Inc. I further understand Camden on Gauley Medical Center, Inc. will rely on such information to determine the allowable discount for my accounts.

I agree to report any changes in my family's size, income or insurance coverage to Camden on Gauley Medical Center, Inc. before or at the time of my family's next contact with Camden on Gauley Medical Center, Inc. I know that the information I have given will continue to be relied upon until such time as my next renewal is due. I know that the information and support documentation supplied with my application may be reviewed by an auditor of any patient assistance program from which I may benefit.

I understand that my discount status will be reviewed either semi-annually or annually, dependent on whether this is my first or subsequent application. At the time of the scheduled renewal or at any time when changes in either family size or income occur, my discount percentage can be adjusted.

If Camden on Gauley Medical Center, Inc. has reason to suspect that the information I have given is untrue, misleading, or incomplete, or if changes in family's size, income, or insurance coverage are not reported as agreed, Camden on Gauley Medical Center, Inc. reserves the right to initiate a review of my pay status: at which time I will be asked to supply documentation supporting my current situation. If I refuse such a review, Camden on Gauley Medical Center, Inc. will no longer discount my account or my family's accounts.

Please note that Camden Family Health includes all Camden Family Health Locations.

X _____ X _____

Responsible Party Date

_____ _____

Relationship to Responsible Party Date
(If signed by someone other than him/her)

X _____ _____

Advocate/Processor Date

I realize that knowingly giving false information in this case may result in criminal prosecution under the laws of the State of West Virginia.

REVISED 02/12/2020

Form **4506T-EZ**
(June 2019)
Department of the Treasury
Internal Revenue Service

Short Form Request for Individual Tax Return Transcript

► Request may not be processed if the form is incomplete or illegible.
► For more information about Form 4506T-EZ, visit *www.irs.gov/form4506tez*.

OMB No. 1545-2154

Tip. Use Form 4506T-EZ to order a 1040 series tax return transcript free of charge, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number or individual taxpayer identification number on tax return
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Year(s) requested.** Enter the year(s) of the return transcript you are requesting (for example, "2008"). Most requests will be processed within 10 business days.

2019 | 2018 | | |

Note. *If the IRS is unable to locate a return that matches the taxpayer identity information provided above, or if IRS records indicate that the return has not been filed, the IRS will notify you that it was unable to locate a return, or that a return was not filed, whichever is applicable.*

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am the taxpayer whose name is shown on either line 1a or 2a. If the request applies to a joint return, **either** spouse must sign. **Note:** This form must be received by IRS within 120 days of the signature date.

☑ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506T-EZ.** See instructions.

Sign Here	Signature (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
	Spouse's signature	Date	

Self-Attestation of Zero Income

As a Federally Qualified Health Center, Camden Family Health is required to verify the household income of patients accessing services. To comply with this requirement, we ask your cooperation in supplying the information requested in the Attestation below. The information will be kept confidential and used only for the purpose of establishing your eligibility.

Certification

I, _____, do hereby certify that I do NOT receive the following income from ANY source. I understand sources of income include, but are not limited to, the following:

- Wages, Salaries, and Tips
- Social Security Benefits
- Unemployment Compensation
- Self-employment or Business Income
- Alimony
- Retirement and Pension Income
- Investment and Rental Income
- Other Taxable Income

Please explain how you (or your family) have paid for these living expenses when your household has had no income.

Food: _____

Utilities: _____

Housing: _____

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to disqualification from the Sliding Fee Discount Program.

Name: _____ DOB: _____

Address: _____

_____ _____

Patient Signature Witness Signature

_____ _____

Date Date