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 09/10/15

Camden Family Health
Sliding Fee Scale Application

Name:			
Address:			
City:		State:	Zip:
Telephone:	( )	Cell Phone: ( )	
Sex:	Male Female	Marital Status: S M D W Separated	
Social Security #:		Birthday:	
Head of Household:			
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 ___W2'S

___ A- Valid WV ID
___ A- Military ID
___ A- WV Voter Reg'n
___ A- WV Mail in Name

___ A- WV Utility bill
___ A- WV Real Estate taxes
___ B-Valid Social Security
___ B-Birth Certificate (w/seal)

___ SSA letter (6-mo)
___ DHHR letter (6-mo)

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 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 mine 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.

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Three Types of Information Required When Applying for Sliding Scale

INCOME:

All income of all family* members.

*Family is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people i(including related subfamily members) are considered as members of one family.

Sources of income include, but are not limited to:

Full month pay stubs (most recent 30 days of pay information)

Social security or SSI (1099 or letter from Social Security Office)
NOTE: Bank statements showing auto-deposit are not acceptable

Child support (Letter showing the amount)

Alimony (Letter showing the amount)

Pensions (1099 or letter showing the amount)

Unemployment (Stubs or letter showing the weekly benefit amount)

HOUSEHOLD:

Complete tax forms (1040 and W2's) from most recent year if one was filed

U.S. RESIDENCY:

An unexpired passport; **OR**
One item from List A and List B:

List A:	***AND***	***List B:***
Valid State Issued Driver's license		*U.S. Social Security Card*
Valid State Issued Photo ID		*Original or Certified Copy of birth record*
School Photo ID		*Certification of Birth Abroad*
Voter's Registration Card		*US Citizen ID Card*
Military ID card or draft record		*Resident Citizen of the US ID card*

Applications can be taken to any Camden Family Health location (Including School-Based Health Center)

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Sources of Income
Income includes ***BUT*** is not limited to the following sources:

Employment Income:
Wages
Salaries
Commissions
Bonuses
Vacation Pay
Profit Sharing
Self-employment
Daycare Provider Income
Adult Care Provider Income
Sick Benefits

Government Benefits:
Social Security Payments
Welfare Checks
Foster Care Payment
SSI Payments
Guardianship Payments

Educational Income:
Student Workstudy
Student Loans
Student Workship

Miscellaneous Benefits:
Veterans Benefits
Disability Benefits
Strike Benefits
Workers Comp Benefits
Retirement Benefits
Black Lung Benefits
Railroad Benefits
Unemployment

Other:
Child support
Insurance Proceeds
Rental Income
Sale of Property
Alimony
Royalties
Annuity Payments
Dividends

Income is calculated with the following formulas, according to pay schedule:

Weekly: Average gross of 4 pays* x 52 weeks ÷ 12 months = Average monthly income
Bi-weekly: Average gross of 2 pays* x 26 weeks ÷ 12 months = Average monthly income
Semi-monthly: Total gross of 2 pays* = Average monthly income
Monthly: Gross of 1 pay* = Average monthly income
Self-Employed: AGI ÷12 months = Average monthly income

*** Pays must be most recent, consecutive and dated within the last 45 days**

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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