For CCCHC Use Only
Poverty Level:_____
Income:_____
Effective Date:_____
Expiration Date:_____

COAL COUNTRY COMMUNITY HEALTH CENTER
SLIDING FEE SCALE APPLICATION

- **SECTION A**

Responsible Party: _____
Last Name First Name M.I. Date of Birth
Billing Address: _____
City State ZIP Code
Home Phone:_____Work Phone:_____Cell Phone:_____

Social Security #:_____ Employer:_____

- **SECTION B**

Please complete table for yourself and all other individuals in the household regardless of insurance status:

NOTE: (DO NOT list individuals for which the responsible party is not LEGALLY responsible)

Last Name, First Name	Date of Birth	Receives Income Y/N	Health Coverage Y/N	Insurance Carrier: Medicaid, Medicare, BCBS, CHIP, etc.
(self)				

- **SECTION C – Complete each section for which your household receives income and PROVIDE DOCUMENTATION**

SOURCES OF INCOME	TOTAL ANNUAL HOUSEHOLD INCOME	ACCEPTED DOCUMENTATION
WAGES – Income received from employment		Last Federal Income tax return, last **two** paystubs prior to the signature date on this application OR letter from employer stating average hours/wages paid for new employment
Interest/Dividend Income		Bank/CU/Savings statement or 1099
Self-Employment, Rental Income		Ledger or income and expenses for the current year or prior year income taxes
Public Assistance (TANF), Food Stamps/SNAP		Award Letter(s) listing amount received in the current year.
SSI/Disability		Award Letter(s) listing amount received in the current year.
Unemployment Compensation		Benefit Award Letter for the current year
Workers' Compensation		Benefit Award Letter for the current year
Child Support, Alimony		Divorce Decree stating child support or alimony received
Retirement/Pension		Letter supplied by system administrator with monthly benefit amount for the current year
Assistance from Family/Friends		A statement from family or friends explaining any financial help they provide you
Other (specify)		

- **SECTION D**

Please read carefully before signing:

I understand that there will be a nominal fee of up to $10 due at the time of service for appointments with a provider, and I believe this nominal fee is reasonable for the services and discount provided through the Sliding Fee Scale Program. I also understand that any labs processed at Coal Country Community Health Center will qualify for the SFS, but any lab work that is sent to an outside lab for processing will be my financial responsibility.

X_____ _____

Applicant Signature Date

_____ _____

CCCHC Financial Counselor Signature Date

Proof of Income:

Proof of income is required. By signing below, I agree that Coal Country Community Health Center (CCCHC) staff may contact each employer of all people working in the home and/or may contact other agencies to confirm the income listed. Within 30 days, I will give CCCHC a copy of all information asked for, for all people in the home to see if I qualify for reduced fees. So that the CCCHC may have a current Billing Form on file, I will be asked to reapply for the program annually. **I will update my application if the people living in my home change, our income changes, or our insurance changes.** If I do not send in proof of information or provide correct information, I may not be eligible for reduced fees.

Applicants who currently receive NO INCOME must complete the non-income verification form. (see page 3 of application)

X_____ _____

Applicant Signature Date

Coal Country Community Health Center offers a dental voucher program to our Sliding Fee Patients.

☐ Yes, I am interested in learning more about the sliding fee dental program through CCCHC

☐ No, I am not interested in learning more about the sliding fee dental program through CCCHC

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Total Annual Income: $_____ Sliding Fee Scale Discount: _____

CCCHC Representative Signature: _____Date:_____

CCCHC Representative Signature: _____Date:_____

Notes:_____

_____

Non-Income Verification for Sliding Fee Scale

Name of Applicant:_____ **Date:**_____
(Please Print)

Name of 3rd Party:_____
(Please Print)

3rd Party Phone Number:_____

3rd Party Address:_____

_____

_____

I, _____, certify to my best knowledge that
(Print name of 3rd party)

_____, a patient at CCCHC, has no income at this time.
(Print name of applicant)

X_____ _____
3rd Party Signature Date

X_____ _____
Applicant Signature Date

*CCCHC requires proof of no income for those applying for the Sliding Fee Scale Program. A 3rd party signature is required by an adult 18 or older to verify the applicant is unemployed and/or not collecting any income at this time. **Please have a 3rd party sign above.**

Coal Country Community Health Centers