SLIDING FEE APPLICATION

P.O. Box 217, Rock Cave, WV 26234 Phone:(304) 924-6262

SF Exp. Date	
Pt Acct #	
Spouse Acct #	
Total Annual Income	*$*
# in Household	
Sliding Fee Tier	
____Entered in EHR	Letter Sent ___Approved ___Denied

PATIENT INFORMATION:

*Name:*_____ *Date:* _____
Address: _____ *Phone:* _____
City: _____ *State:* ____ *ZIP:* _____ *County:*_____
_____

Do you or your spouse have Health Insurance? *YOU: NO _____ YES _____ SPOUSE: NO_____ YES_____*
If yes, what kind? *Commercial Ins. Plan: _____ WV Medicaid_____ Medicare_____* ***(Please show Insurance Card)***
**** IT IS TO YOUR BENEFIT TO LET US KNOW IF YOU HAVE ANY INSURANCE. YOU WILL ONLY BE RESPONSIBLE FOR THE SLIDING FEE AMOUNT, HOWEVER WE STILL NEED TO BILL ANY INSURANCE PLANS THAT YOU MAY HAVE***

VERIFICATION OF INCOME MUST BE PROVIDED TO PROCESS THIS APPLICATION

FAMILY INFORMATION AND INCOME: *LIST **ALL** PERSONS WHO YOU PLAN TO INCLUDE ON YOUR TAX RETURN - **INCLUDING YOURSELF** (GENERAL HOUSEHOLD FORMULA: TAX FILER+SPOUDE+TAX DEPENDENTS=HOUSEHOLD). LIST **ALL** INCOME RECEIVED BY EACH PERSON IN HOUSEHOLD.*

FULL NAME (First Middle Last)	**RELATIONSHIP TO APPLICANT**	**PATIENT OF CCWV YES/NO**	**DATE OF BIRTH**	**MODIFIED ADJUSTED GROSS YEARLY INCOME** (Verification of income **must** be sent with this application)	**SOURCE # (SEE LIST BELOW)**
1					
2					
3					
4					
5					
6					
7					

***SOURCE OF INCOME (LIST # ON LINES ABOVE)**
1-GROSS WAGES/CONTRACT LABOR
2-UNEMPLOYMENT
3-SOCIAL SECURITY
4-DISABILITY (SSDI)
5-PENSIONS/RETIREMENT
6- BONUSES, TIPS, COMMISSIONS
7-ALIMONY
8- OTHER (Interest, Dividends, Royalties, etc.)

By signing below: I REQUEST COMMUNITY CARE OF WEST VIRGINIA TO MAKE A DETERMINATION OF MY ELIGIBILITY FOR DISCOUNTED SERVICES BASED UPON THE INFORMATION I HAVE PROVIDED. I UNDERSTAND THE INFORMATION I SUBMIT CONCERNING MY INCOME AND FAMILY SIZE IS SUBJECT TO VERIFICATION AND THAT I HAVE SUPPLIED ALL REQUIRED DOCUMENTATION. I UNDERSTAND THAT MY INFORMATION MAY BE SUPPLIED TO THE WV DEPT OF HEALTH AND HUMAN RESOURCES FOR PURPOSES OF VERIFYING ELIGIBILITY. I AFFIRM ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT ***IF INFORMATION I HAVE SUBMMITTED IS DETERMINED TO BE FALSE, IT WILL RESULT IN DENIAL OF DISCOUNTED SERVICES AND THAT I WILL BE LIABLE FOR CHARGES FOR SERVICES PROVIDED AND IT MAY RESULT IN CRIMINAL CHARGES.***

PATIENT'S SIGNATURE: _____ ***DATE:*** _____

CCWV - REVIEWED/APPROVED BY:_____ ***DATE:*** _____

Sliding Fee Information and Application Instructions

Community Care of West Virginia has a program which offers reduced rates. The Sliding Fee Program is based on your Modified Adjusted Gross Income and the number of members in your family that you plan to file a tax return with.

The following explains the various tiers and how they apply to the discounts:

Family Practice

Tier 1- This is the biggest discount that we offer on the Sliding Fee Program. Under this tier the total amount the patient pays for each procedure or visit is the lesser of $15.00 or the total patient responsibility amount.

Tier 2-Under this tier, the total amount the patient pays for each procedure or visit is the lesser of $30.00 or the total patient responsibility amount.

Tier 3- Under this tier, the total amount the patient pays for each procedure or visit is the lesser of $45.00 or the total patient responsibility amount.

Tier 4- Under this tier, the total amount the patient pays for each procedure or visit is the lesser of $60.00 or the total patient responsibility amount.

Dental

Tier 1- This is the biggest discount that we offer on the Sliding Fee Program for Dental. Under this tier the nominal fee for each dental visit, restorative or service is $20.00 each. The nominal fee for High-level Dental Services (such as temporary dentures/partials, bridges, and root canals) will be $300.00 for each. The nominal fee for High-level Permanent Dental Services will be $450.00.

Tier 2- Under this tier, the total amount the patient pays for each procedure or visit is the lesser of 60% of the total charge, or $21 (for preventative/other dental services), or $301 (for High-level Temporary Dental Services) or $451 (for Permanent High-level Dental Services).

Tier 3- Under this tier, the total amount the patient pays for each procedure or visit is the lesser of 70% of the total charge, or $21 (for preventative/other dental services), or $301 (for High-level Temporary Dental Services) or $451 (for Permanent High-level Dental Services).

Tier 4- Under this tier, the total amount the patient pays for each procedure or visit is the lesser of 80% of the total charge, or $21 (for preventative/other dental services), or $301 (for High-level Temporary Dental Services) or $451 (for Permanent High-level Dental Services).

The Sliding Fee discount can be used in conjunction with Medicare and Insurance to help with the co-pay and deductible amounts to reduce the amount the patient has to pay. These amounts can be reduced to $15.00 per procedure if the patient falls in the 100% range.

Patients are not required to be uninsured to qualify for sliding fee. Patients who qualify under the household income and Federal Poverty guidelines are eligible for sliding fee even if they have the following insurances:

*Medicaid *Medicare *Commercial Insurance

TO APPLY YOU MUST:

*Fill out this application.
*BRING in proof of modified adjusted gross income for all those in the household. Proof of income accepted are as follows:

- W-2, TAX FORMS
- CHECK STUBS
- BANK STATEMENTS
- LETTER FROM EMPLOYER

IF YOU HAVE A QUESTION OR NEED MORE INFORMATION ABOUT SLIDING FEE OR THIS APPLICATION, PLEASE FEEL FREE TO CALL OUR OFFICE AT (304) 924-6262.

ALL INFORMATION IS CONFIDENTIAL.