SLIDING FEE APPLICATION

Community Care of West Virginia

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

SF Expiration Date	
Pt Acct #	
Spouse Acct #	
Total Annual Income	**$**
Entered in MM_____	Card
Entered in EHR____	Letter

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 LIVING IN YOUR HOUSEHOLD **INCLUDING YOURSELF**. 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**	**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
5-PENSIONS/RETIREMENT
6-CHILD SUPPORT
7-ALIMONY
8-AFDC/SSI
9-FOOD STAMPS
10-WORKERS COMP
11-OTHER (Interest, Dividends Royalties, etc)

*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: _____

****CLINIC USE ONLY!!!!****

CLINIC CALCULATION OF SLIDING FEE RATE

A. TOTAL FAMILY INCOME $_____ B. APPLICATION POVERTY LEVEL_____

C. ANNUAL FAMILY INCOME AS PERCENT REDUCTION_____ D. APPLICATION FEE

POVERTY LEVEL (A/B/C)_____

REVIEWED BY: _____ DATE: _____

APPROVED BY: _____ DATE: _____

ATTENTION

Community Care of West Virginia has a program which offers reduced rates. The Sliding Fee Program is based on your Gross Income and the number of members in your family.

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 charge amount

Tier 2-Under this percentage the total amount the patient pays for each procedure or visit is the greater of $15.00 or 30% of the total charge amount

Tier 3- Under this percentage the total amount the patient pays for each procedure or visit is the greater of $15.00 or 40% of the total charge amount

Tier 4- Under this percentage the total amount the patient pays for each procedure or visit is the greater of $15.00 or 50% of the total charge 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. Temporary Dentures/Partials, Bridges, and Root Canals will be $300.00 for each. Permanent Denture/Partials will be $450.00.

Tier 2- You will be responsible for 60% of the total charge.

Tier 3- You will be responsible for 70% of the total charge.

Tier 4- You will be responsible for 80% of the total charge.

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 house hold income and Federal Poverty guidelines are eligible for sliding fee even if they have the following:

*Medicaid *Insurance *Medicare

TO APPLY YOU MUST:

*Fill out this application.

*BRING in proof of gross income for all those over 18 in the household. Proof of income accepted are as follows:

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

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.