AccessHealth

Community Health Systems, Inc.
Sliding Fee Scale Appllication

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

Household (claimed on most recent tax return, or otherwise documented):

Name	Relationship	Birthdate	Social Security #	Ins Y/N	PIN Y/N

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

Applicant's Signature: X _____ **Date:** _____

Applicant's Signature: X _____ **Date:** _____

ADMINISTRATIVE USE ONLY:

Name	Income Source	Average Monthly Amount
		$
		$
		$
		$

Total monthly GROSS income: $_____

Reviewed By: _____

Date: _____

Based on the family size and the income information provided, this patient/family is hereby assigned a pay status of (please circle): Sliding Scale: Nominal Fee $5, 20%, 40%, 60%, 80%

(Labs are included in total charges if done on same day as visit)

Service Notes:

Community Health Systems, Inc./dba AccessHealth
Statement of Understanding

The information I have given concerning my family's gross monthly/annual income from all source 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 account 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 Community Health Systems, Inc./AccessHealth. I further understand Community Health Systems, Inc./AccessHealth will rely on such information to determine the allowable discount for my accounts.

I agree to report any changes in my household's size, income or insurance coverage to Community Health Systems, Inc./AccessHealth before or at the time of my family's next contact with Community Health Systems, Inc./AccessHealth. 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 Community Health Systems, Inc./AccessHealth has reason to suspect that the information have given is untrue misleading\, or incomplete, or if changes in household's size, income or insurance coverage are not reported as agreed, Community Health Systems, Inc./AccessHealth 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, Community Health Systems, Inc.AccessHealth will no longer discount my or my family's accounts.

Please note that Community Health Systems, Inc./ AccessHealth includes:

AccessHealth Rural Acres
AccessHealth Stanaford
AccessHealth Glen Daniel
AccessHealth Mabscott
AccessHealth Daniels
AccessHealth Professional Medical Ultrasonics
AccessHealth Williamsburg
AccessHealth Fayette
AccessHealth OB/GYN
AccessHealth Bill Baker Way
AccessHealth Mental Health
AccessHealth Pediatrics
AccessHealth Princeton

Signature	Date	Relationship
_____	_____	_____
Applicant Name:		
_____	_____	_____
Applicant Name:		
_____	_____	_____
Processor:		

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

AccessHealth

Information Required
When Applying for Sliding Scale

INCOME (all income for all household* members)

HOUSEHOLD (individuals claimed on your tax return, or proven by other legal document)

Sources of income include, but are not limited to:

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

Social Security or SSI letter **ONLY: (1099's are no longer acceptable)**
NOTE: Bank statements showing auto-deposit are not acceptable

Child support (DHHR document or letter showing the amount)

Alimony (1099 or letter showing the amount)

Pensions (1099 or current Bank Statement)

Unemployment (Letter showing the weekly benefit amount)

Complete tax forms (federal 1040 and w2's) from most recent year if one was filed

Photo ID required for proof of Identity
If *NO* ID available, may use from list below

List

*Valid Driver's license**
*Valid Photo ID**
Voter's Registration Card
US Mail showing physical address
Military ID card or draft record

Photo ID required: if expired or incorrect, then other form of ID required

ATTENTION: **CHILDREN AND INDIVIDUALS WITH NO INCOME:**

ALL MINOR CHILDREN MUST submit an application to DHHR for coverage through CHIPS or Medicaid. ***No Children can receive the Sliding Fee Scale benefit.***

Individuals with no income MUST submit an application to DHHR or SSA and present verification of application. (A sliding scale card can be issued for 30 days allowing time to receive a Medicaid card, denial letter or other communication from DHHR or SSA on the status of the application. Individuals must present DHHR/SSA response to AccessHealth or be removed from the sliding scale program.)

APPLICATION MAY BE SUBMITTED AT THE FOLLOWING CHS LOCATIONS:

ACCESSEALTH PHARMACIES:
Rural Acres, Glen Daniel and Fayette
Monday – Friday 9:00 am – 12:00 am and 1:00 – 3:00pm
No appointment necessary

Revised 11/10/2023

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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 Loans

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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AccessHealth Mabscott
AccessHealth Daniels
AccessHealth Professional Medical Ultrasonics
AccessHealth Williamsburg
AccessHealth Fayette
AccessHealth OB/GYN
AccessHealth Bill Baker Way
AccessHealth Mental Health
AccessHealth Pediatrics
AccessHealth Princeton

AccessHealth

Sliding Fee Scale Program Agreement

I/we agree that the following information was explained to me/us, and that I/we will follow ALL the guidelines of this program. I/we understand that:

1. Services that are eligible under other programs such as CHIP (Children's Health Insurance Program), Family Planning, Breast and Cervical Cancer Screening, and others are not discounted under this program. Households at or below 100% Federal Poverty Guidelines may receive reduced or waived copayments and deductibles.

2. Only services that are medically necessary, and ordered and performed on-site by an **Access**Health provider are discounted under this program.

3. Administrative exams, labs, and vaccines for employment, school, etc., are not covered under this program.

4. Some in-office procedures may not be covered by this program. It is my/our responsibility to ask if the procedure is covered. If it is not covered, the Billing staff may assist to make payment arrangements.

5. Laboratory services performed at **Access**Health are discounted under this program. (Some lab specimens are collected at **Access**Health, but processed at an outside lab. These services **may** or **may not** be discounted at the laboratory used for testing.)

6. This program does not discount or pay for hospital services of any kind, in- or out-patient. It does not discount fees for any specialists, procedures, or services performed by providers outside of **Access**Health.

7. **Access**Health Patient Benefits staff will determine the effective dates for participation in this program. Enrollment is generally valid for one year, but **Access**Health may approve shorter periods in certain situations.

8. **I/We must present a valid Sliding Fee Scale card at every visit to receive the discount on services from Access**Health **providers.**

9. I/We must notify **Access**Health if there is any change in income or household before it is time to renew my/our participation in the program.

10. I/We must submit all required documentation of income, household and residency. **Access**Health may request verification of income, household or residency at any time during my/our participation in the program.

11. For medications ordered for me through the PIN program, I understand that I must give the Patient Advocate 30-days notice to re-order the medication(s).

12. **SLIDING FEE SCALE AMOUNT IS DUE AT THE TIME OF SERVICE. NO FUTURE APPOINTMENT WILL BE SCHEDULED IF AN UNPAID BALANCE EXISTS.**

Applicant_____ _____
Signature Date

Print Name_____

Processor_____ _____

AccessHealth

3rd Party Verification

Please review and mark any fields that may apply to your circumstance.

The Marketplace Insurance (Obamacare)

- ☐ Applied
- ☐ Denied
- ☐ Refused
- ☐ In Appeals Process
- ☐ Incomplete
- ☐ Submitted Application/Plan not selected
- ☐ Plan Selected Premium not paid
- ☐ Exempt

- ☐ Not Interested
- ☐ Will Apply During Open Enrollment
- ☐ Premium too High

If Exempt , please state reason for exemption/documentation required:_____

Please review list of requirements for special enrollment in The Marketplace Insurance

Qualifying life event
Birth of a child
Marriage
Adoption
Foster Care
Relocation
Gaining Citizenship
Leaving incarceration
Loss of other health coverage
Cobra expiration

Aging off of parents plan
Loss of eligibility of Medicaid/Chip
Enrollment Errors
Domestic violence (Limited)
Change of income or household status
Religion

Documentation required at time of Enrollment

Medicaid

- ☐ Medicaid/Chip application in process
- ☐ Approved
- ☐ Denied

Applicant Signature: _____ Date: _____

Processor Signature: _____ Date: _____