**Collettsville Medical Center**
**Old Highway 90/ PO Drawer 9**
**Collettsville, NC 28611**
**(828) 754-2409 Fax (828) 2418**

***http://www.westcaldwellhc.org***

**Happy Valley Medical Center**
**Highway 268 / PO Box 319**
**Patterson, NC 28661**
**(828) 754-6850 Fax (828) 757-3214**

# SLIDING SCALE DISCOUNT PROGRAM

West Caldwell Health Council, Inc. offers a sliding fee scale to patients according to their income and ability to pay. You may apply regardless of whether you have insurance coverage or not. Patients must complete the application and provide proof of their total household income *as is required by federal regulations.*

**** * If ALL required documentation is not received, your application will be DENIED and you will be responsible for all charges incurred! Income from all sources must be included for everyone living in the household. This includes each person living in the same structure regardless of relationship.***

**RETURN COMPLETE APPLICATION TO:** COLLETTSVILLE MEDICAL CENTER
Attn: Wanda Ellis, Outreach and Enrollment Coordinator
P. O. Drawer 9
Collettsville, NC 28611
(Phone: 828-754-2409, ext. 104)

| **PRIMARY APPLICANT**: (LAST) | (FIRST) | (MIDDLE) | |
|---|---|---|---|
| MAILING ADDRESS: | | | |
| PHYSICAL/STREET ADDRESS: | | | |
| EMAIL ADDRESS(IF APPLICABLE): | | | |
| TELEPHONE NUMBER: | | ALTERNATE PHONE: | |
| DATE OF BIRTH: | RACE | GENDER | SSN: |
| ARE YOU A MILITARY VETERAN: Y / N | | DID YOU FILE TAXES? Y / N | |
| APPLYING FOR SSI/SS DISABILITY: Y / N | | FULL TIME STUDENT: Y/ N | |
| MARITAL STATUS: (CIRCLE) SINGLE, MARRIED, DIVORCED, WIDOWED, LEGALLY SEPARATED WITH PAPERS FILED WITH COURT, SEPARATED BUT NO LEGAL PAPERS FILED WITH COURT | | | |
| *EMPLOYER*_________________________________________ WEEKLY BI-WEEKLY MONTHLY OTHER________(CIRCLE) | | | |

*CHECK& PROVIDE AMOUNTS FOR ALL THAT APPLY:*

- ☐ *WAGES_____________________(provide copies of three most recent pay stubs or notarized statement by employer if cash only)*
- ☐ *SELF-EMPLOYED_____________(include Schedule C)*
- ☐ *SOCIAL SECURITY________________(provide either annual determination letter or a bank statement that reflects the direct deposit amount)*
- ☐ *SS DISABILITY________________(provide either annual determination letter or a bank statement that reflects the direct deposit amount)*
- ☐ *SSI(MEDICAID ELIGIBLE)______________ (provide either annual determination letter or a bank statement that reflects the direct deposit amount)*
- ☐ *VETERAN BENEFITS___________ ( provide either annual determination letter or a bank statement that reflects the direct deposit amount)*
- ☐ *UNEMPLOYMENT_______________(include ESC printout)*
- ☐ *RETIREMENT INCOME________________(vouchers or annual statement)*
- ☐ *WORKER'S COMP______________(provide award letter or 3 check stubs)*
- ☐ *ALIMONY/CHILD SUPPORT____________(include copy of legal agreement or decree)*
- ☐ *DIVIDEND/INTEREST INCOME ___________(prior year 1099)*
- ☐ *PENSION/ANNUITIES ________________(prior year 1099)*
- ☐ *RENT, ROYALTIES, ESTATES, TRUSTS _____________ ( Include receipts, general journal pages, legal decrees as applicable)*
- ☐ *FOOD STAMPS_____________( provide annual determination letter)*
- ☐ *COLLEGE FINANCIAL AID_______________ (award letter, vouchers, etc.)*
- ☐ *ASSISTANCE FROM FAMILY & FRIENDS __________ (notarized statement from person providing assistance)*
- ☐ *OTHER INCOME (PLEASE EXPLAIN )________________ ________________________________________________*

| **HOUSEHOLD MEMBER #2:** (LAST) | | (FIRST) | (MIDDLE) |
|---|---|---|---|
| MAILING ADDRESS: | | | |
| PHYSICAL/STREET ADDRESS: | | | |
| EMAIL ADDRESS(IF APPLICABLE): | | RELATION TO PRIMARY APPLICANT | |
| TELEPHONE NUMBER: | | ALTERNATE PHONE: | |
| DATE OF BIRTH: | RACE | GENDER | SSN: |
| ARE YOU A MILITARY VETERAN: Y / N | | DID YOU FILE TAXES? Y / N | |
| APPLYING FOR SSI/SS DISABILITY: Y / N | | FULL TIME STUDENT: Y/ N | |

MARITAL STATUS: (CIRCLE) SINGLE, MARRIED, DIVORCED, WIDOWED, LEGALLY SEPARATED WITH PAPERS FILED WITH COURT, SEPARATED BUT NO LEGAL PAPERS FILED WITH COURT

*EMPLOYER*_____________________________________________________ WEEKLY BI-WEEKLY MONTHLY OTHER_________(CIRCLE)

*CHECK & PROVIDE AMOUNTS FOR* ***ALL*** *THAT APPLY:*

- ☐ *WAGES*_____________________(*provide copies of three most recent pay stubs or notarized statement by employer if cash only*)
- ☐ *SELF-EMPLOYED*_____________(*include Schedule C*)
- ☐ *SOCIAL SECURITY*_________________(*provide either annual determination letter or a bank statement that reflects the direct deposit amount*)
- ☐ *SS DISABILITY*________________(*provide either annual determination letter or a bank statement that reflects the direct deposit amount*)
- ☐ *SSI(MEDICAID ELIGIBLE)*______________ (*provide either annual determination letter or a bank statement that reflects the direct deposit amount*)
- ☐ *VETERAN BENEFITS*___________ ( *provide either annual determination letter or a bank statement that reflects the direct deposit amount*)
- ☐ *UNEMPLOYMENT*_______________(*include ESC printout*)
- ☐ *RETIREMENT INCOME*________________(*vouchers or annual statement*)
- ☐ *WORKER'S COMP*______________(*provide award letter or 3 check stubs*)
- ☐ *ALIMONY/CHILD SUPPORT*____________(*include copy of legal agreement or decree*)
- ☐ *DIVIDEND/INTEREST INCOME* ___________(*prior year 1099*)
- ☐ *PENSION/ANNUITIES* ________________(*prior year 1099*)
- ☐ *RENT, ROYALTIES, ESTATES, TRUSTS* _____________ (*Include receipts, general journal pages, legal decrees as applicable*)
- ☐ *FOOD STAMPS*_____________( *provide annual determination letter*)
- ☐ *COLLEGE FINANCIAL AID*_______________ (*award letter, vouchers, etc.*)
- ☐ *ASSISTANCE FROM FAMILY & FRIENDS* __________ (*notarized statement from person providing assistance*)
- ☐ *OTHER INCOME (PLEASE EXPLAIN )*________________ ___________________________________________________

| **HOUSEHOLD MEMBER #3**: (LAST) | | (FIRST) | (MIDDLE) |
|---|---|---|---|
| MAILING ADDRESS: | | | |
| PHYSICAL/STREET ADDRESS: | | | |
| EMAIL ADDRESS(IF APPLICABLE): | | RELATION TO PRIMARY | |
| TELEPHONE NUMBER: | | ALTERNATE PHONE: | |
| DATE OF BIRTH: | RACE | GENDER | SSN: |
| ARE YOU A MILITARY VETERAN: Y / N | | DID YOU FILE TAXES? Y / N | |
| APPLYING FOR SSI/SS DISABILITY: Y / N | | FULL TIME STUDENT: Y/ N | |

MARITAL STATUS: (CIRCLE) SINGLE, MARRIED, DIVORCED, WIDOWED, LEGALLY SEPARATED WITH PAPERS FILED WITH COURT, SEPARATED BUT NO LEGAL PAPERS FILED WITH COURT

*EMPLOYER*__________________________________________________ WEEKLY BI-WEEKLY MONTHLY OTHER_________(CIRCLE)

Documentation for household member #3 continues to next page

| *CHECK& PROVIDE AMOUNTS FOR **ALL** THAT APPLY:* | |
|---|---|
| ☐ *WAGES_____________________(provide copies of three most recent pay stubs or notarized statement by employer if cash only)* | ☐ *WORKER'S COMP_____________(provide award letter or 3 check stubs)* |
| ☐ *SELF-EMPLOYED_____________(include Schedule C)* | ☐ *ALIMONY/CHILD SUPPORT___________(include copy of legal agreement or decree)* |
| ☐ *SOCIAL SECURITY_______________(provide either annual determination letter or a bank statement that reflects the direct deposit amount)* | ☐ *DIVIDEND/INTEREST INCOME __________(prior year 1099)* |
| ☐ *SS DISABILITY_______________(provide either annual determination letter or a bank statement that reflects the direct deposit amount)* | ☐ *PENSION/ANNUITIES _______________ (prior year 1099)* |
| ☐ *SSI(MEDICAID ELIGIBLE)_____________ (provide either annual determination letter or a bank statement that reflects the direct deposit amount)* | ☐ *RENT, ROYALTIES, ESTATES, TRUSTS _____________ ( Include receipts, general journal pages, legal decrees as applicable)* |
| ☐ *VETERAN BENEFITS__________ ( provide either annual determination letter or a bank statement that reflects the direct deposit amount)* | ☐ *FOOD STAMPS___________( provide annual determination letter)* |
| ☐ *UNEMPLOYMENT______________(include ESC printout)* | ☐ *COLLEGE FINANCIAL AID______________ (award letter, vouchers, etc.)* |
| ☐ *RETIREMENT INCOME______________(vouchers or annual statement)* | ☐ *ASSISTANCE FROM FAMILY & FRIENDS __________ (notarized statement from person providing assistance)* |
| | ☐ *OTHER INCOME (PLEASE EXPLAIN )_______________ __________________________________________________* |

***You may copy pages of this application as needed to fully disclose all applicable information for all household members.**

**Household Member #4**

Name ______________________________________________ Relation to Primary Applicant_____________________
Date of Birth_______________Race_________Gender________ Social Security #_______________________________
Medicaid? _________________Health Insurance _________________________________________________________
Veteran? ________ Employed? ________________________________________________ File Taxes?_____________ _
Full Time Student?___________ List income from ALL sources _____________________________________________
Patient of West Caldwell Health Council? __________ ______________________________________________

**Household Member #5**

Name______________________________________________ Relation to Primary Applicant____________________
Date of Birth________________Race_________Gender________ Social Security #_____________________________
Medicaid?__________________Health Insurance _____________________________________________________
Veteran? ________ Employed? ________________________________________________ File Taxes?____________
Full Time Student?___________ List income from ALL sources _____________________________________________
Patient of West Caldwell Health Council? __________ _____________________________________________

**ADDITIONAL REQUIRED DOCUMENTATION**

- If you are not employed nor receive monthly benefits from SSA, SSA disability, etc., you must obtain a Wage History Report from the Employment Security Commission in Raleigh (This **cannot** be obtained in the local ESC office). An order form can be provided to you upon request.
- If none of the above income sources apply to you, please get notarized statements from each person providing assistance to you (including shelter, housing, food, and clothing). Be sure to include the amount and frequency of the assistance that you receive.
- A copy of the Federal Income Tax Return (1040) for all members of the household that file. If not required to file, please provide a 4506T "Request for Transcript of Tax Return" that will be used to confirm non-filing status for each.
- Copy of photo ID for all household members over the age of 18.
- Provide a copy of the birth certificate and Medicaid ID card for all children under the age of 18
- Proof of full-time student status for age 18 & up, if applicable

**Under penalty of perjury I declare that I have read this application in its entirety and have provided true and accurate information. I authorize the release of employment and financial records to an agent of West Caldwell Health Council for determination purposes. I agree to notify WCHC of any changes affecting the size or income of my household.**

Applicant's Signature ________________________________________Date________________________