WCCHS
Wyoming County Community Health System

# Sliding Fee Application and Worksheet

**For any questions, please call (585) 786-8940 x-4411**

**Return application to:** **Attention: Account Clerk - Cashier**

Note: INCOMPLETE APPLICATIONS WILL BE RETURNED UNPROCESSED.

Date of Request: _____

Patient's Name: _____ Phone #: _____

Mailing Address: _____

| Other Family Members (Living at Same Address) | Name | DOB | Relationship |
|---|---|---|---|
| (if more space is required, use bottom of page) | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

List: Date of Service Account #

_____

_____

_____

_____



Dev. 03/2015; Rev. 3 (02 06 2020)

**The following income information is mandatory for application to be reviewed:**

**All income must be verified for application to be considered.**

## **Please include copies of all income listed below.**

*Note: Based on review of income, you may be asked to submit Medicaid status information.*

***See Next Page for Determination Criteria***

**Note: BOTH COLUMNS MUST BE COMPLETED**

| Income: List income for family | TOTAL FOR LAST 3 MONTHS | TOTAL FOR LAST 12 MONTHS |
|---|---|---|
| Wages (includes self-employment | | |
| Social Security | | |
| Unemployment Compensation | | |
| Alimony | | |
| Child Support | | |
| Military Family Allotments | | |
| Pension/IRA/Annuities, etc. | | |
| Income from rent | | |
| Income from dividends, interest | | |

I certify that the information is true and accurate to the best of my knowledge. I understand that this application is made so that Wyoming County Community Hospital can judge my eligibility for Community Care benefits as related to New York State Charity Care Guidelines effective January 11, 2019. I understand that this information may be used in discussions with another party to help determine eligibility.

_____

Signature of Person Making Request



Dev. 03/2015; Rev. 3 (02 06 2020)

COMMUNITY CARE CALCULATION:

WCCHS Account Clerk/Cashier will do calculations using a spreadsheet tool to determine patient responsibility. Please see chart below.

| 2020 INCOME LEVELS | | | | | | | |
|---|---|---|---|---|---|---|---|
| | % OF FEDERAL POVERTY LEVEL | | | | | | |
| | | | | | | | |
| | 100% | Up to 200% | 201-250% | 251-300% | 300-350% | 351-400% | Over 401% |
| FAMILY SIZE | | | | | | | |
| 1 | 12,760.00 | 25,520.00 | 31,900.00 | 38,280.00 | 44,660.00 | 51,040.00 | 51,167.60 |
| 2 | 17,240.00 | 34,480.00 | 43,100.00 | 51,720.00 | 60,340.00 | 68,960.00 | 69,132.40 |
| 3 | 21,720.00 | 43,440.00 | 54,300.00 | 65,160.00 | 76,020.00 | 86,880.00 | 87,097.20 |
| 4 | 26,200.00 | 52,400.00 | 65,500.00 | 78,600.00 | 91,700.00 | 104,800.00 | 105,062.00 |
| 5 | 30,680.00 | 61,360.00 | 76,700.00 | 92,040.00 | 107,380.00 | 122,720.00 | 123,026.80 |
| 6 | 35,160.00 | 70,320.00 | 87,900.00 | 105,480.00 | 123,060.00 | 140,640.00 | 140,991.60 |
| 7 | 39,640.00 | 79,280.00 | 99,100.00 | 118,920.00 | 138,740.00 | 158,560.00 | 158,956.40 |
| 8 | 44,120.00 | 88,240.00 | 110,300.00 | 132,360.00 | 154,420.00 | 176,480.00 | 176,921.20 |
| | | | | | | | |
| PERCENTAGE DUE FROM PATIENT | | | | | | | |
| | 0% | 0% | 20% | 40% | 60% | 80% | 100% |
| | | | | | | | |