



# 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 #

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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.

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Signature of Person Making Request

COMMUNITY CARE CALCULATION:

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

INCOME LEVELS		2023 INCOME LEVELS						
FAMILY SIZE		up to 200%	201-250%	251-300%	301-350%	351-400%	Over 401%	
1	\$14,580.00	29,160.00	36,450.00	43,740.00	51,030.00	58,320.00	58,465.80	
2	19,720.00	39,440.00	49,300.00	59,160.00	69,020.00	78,880.00	79,077.20	
3	24,860.00	49,720.00	62,150.00	74,580.00	87,010.00	99,440.00	99,688.60	
4	30,000.00	60,000.00	75,000.00	90,000.00	105,000.00	120,000.00	120,300.00	
5	35,140.00	70,280.00	87,850.00	105,420.00	122,990.00	140,560.00	140,911.40	
6	40,280.00	80,560.00	100,700.00	120,840.00	140,980.00	161,120.00	161,522.80	
7	45,420.00	90,840.00	113,550.00	136,260.00	158,970.00	181,680.00	182,134.20	
8	50,560.00	101,120.00	126,400.00	151,680.00	176,960.00	202,240.00	202,745.60	
Pay % of Bill		0%	0%	20%	40%	60%	80%	100%