Patient Assistance Program
Sliding Fee Discount Program Application & Eligibility Form (D1)

Community Health Center in Cowley County, Inc.
Health Care for Everyone

It is necessary for us to ask personal questions to give you a discount on your medical expenses. This information will be kept on file in our center in strict confidence. You must verify your income at least annually. Your yearly income tax return with a copy of your W-2 form, two most recent paystubs, formal letters from employer, social security benefit letter or other current award letter. Your annual income will be used to calculate the level of discount.

Name:	Today's Date:
Street:	Number of people living in the home:
City & State:	Marital Status: ☐ Photo ID on File
Phone Number:	Place of Employment: Spouses Employer:

HOUSEHOLD INFORMATION MUST BE COMPLETED FOR ALL APPLICANTS		
(Provide names, DOB, and SSN, for **ALL** individuals living in the household)		
Name	Date of Birth	Social Security Number

Total Income				
	You	Spouse	Other Person(s)	Total Resources
Social Security				
Retirement Pension				
Child Support/Alimony				
Other:				
Wages (Monthly)				

SELF-DECLARTION OF INCOME WILL BE ACCEPTED ON CASE-BY-CASE BAISES. ALL SUBSEQUENT VISITS WILL BE CHARGED AT THE FULL FEE UNLESS PROOF OF INCOME IS PROVIDED.

☐ Proof of Income ☐ Form D3: Financial Support ☐ Form D4: Employer Income Verification ☐ Form D7: Self- Declaration

Affidavit: By my signature below, I attest that the information provided herein is complete and accurate; that as of the date of my signature, the income sources listed constitute all my household income, and the household members listed are solely dependent on that income. I understand that I may be required to provide additional information and documentation upon request by the CHCCC Patient Assistance Services Program for determining eligibility to participate in the discount program. I agree to inform CHCCC of any changes of condition or circumstance that might affect my eligibility to participate in the discount program. I also understand any untruthful or fraudulent information provided may be grounds for denial of future assistance.

Printed Name _____ Signature _____ Date _____

FOR OFFICE USE ONLY				
☐ Nominal Fee (A)	☐ 25% (B)	☐ 50% (C)	☐ 75% (D)	☐ No Discount (E)

Discount Valid Until _____ CHCCC Staff Signature _____

PO Box 643, Winfield, KS 67156 Phone: 620.221.3350 Fax: 620.221.6061