CATAWBA VALLEY FAMILY MEDICINE

CLAREMONT

Sliding Scale Fee Application

Documents Required & Provided by Applicant

- **Completed** Sliding Scale Fee Application
- **Identification**
- **Proof of Income** – Provide at LEAST ONE (1) for EACH adult in household:
  - Two most recent paycheck stubs
  - Letter on letterhead from employer stating your current rate of pay & hours in 1 week
  - Most recent W-2 Form
  - Most recent tax return including (1099 Schedule C if Self-Employed)
  - Social Security/Disability Income Statement Letter
  - Unemployment Wage Summary from Employment Security Commission
  - Child Support/Alimony Verification Letter
  - Bank Statement
  - VA/Pension Income
  - Worker's Compensation Benefits
  - A letter that supports your current financial status. (This letter may ONLY come from a minister, priest, rabbi, director of homeless shelter, landlord, or social/case worker.)
  - OTHER (List Specific documentation provided) - _____

    _____

    _____

(For office use only)

Verifications Obtained ******MANDATORY******

Printed screen showing ***a COVERAGE Verification*** obtained at https://webclaims.ncmedicad.com/ncecs/ **OR** https://online.instamed.com

Reviewed and verifications completed by : _____ Date: _____

Eligibility Dates: **START** _____ **STOP** _____ **Copay Med**: _____ % _____

CATAWBA VALLEY HEALTH SYSTEM

Financial Assistance Application

Catawba Valley Medical Group and Specialty Clinics

(Please Print)

Application Date: _____

Patient Information:

Name _____ Date of Birth _____ Social Security # _____

Responsible Party Information:

Name _____

Home Phone # _____ Mobile Phone # _____ Other # _____

Current Address: _____ City: _____ State: _____ Zip code: _____ County: _____

Employer: _____ FT__ PT___ Temp___ How long employed there? _____

Spouse Name: _____ Social Security #: _____

Employer: _____ FT__ PT___ Temp___ How long employed there? _____

Number of people in your household: _____ (Household includes the applicant, spouse, children less than 18 yrs. of age claimed as dependents on your tax returns.) Children's Ages: ___ ___ ___ ___ ___ ___

Do you receive assistance from any other source?

- Medicaid Yes__ No ___ Pending? ___ Approved? ____ Denied? _____ (date)
- Private Policy? If so, what? _____
- Other source? (explain) _____

Do you qualify for health insurance with a federally qualified health plan (ACA)from the Exchange? ___yes ___no

Income: *Please list all sources of income and attach proof of income: either most recent tax return or pay stubs for applicant and spouse. This* ***includes*** *but is not limited to* ***wages, unemployment, social security, retirement pensions, VA, child support, Alimony, investments, or rental income.***

Applicant: Income Type(s): _____ Gross Monthly Amt. $_____

Spouse: Income Type(s): _____ Gross Monthly Amt. $_____

Other: Income Type(s): _____ Gross Monthly Amt. $_____

**If more than one type of income, list on separate sheet.

Assets: ***Please indicate whether individually or jointly owned by circling one.***

Cash and Investments: **Balance:**

Checking	$ _____	Individual or Joint
Savings	$ _____	Individual or Joint
CD's	$_____ Total Value	Individual or Joint
Stocks/Bonds	$_____ Total Value	Individual or Joint

Real Property: Property other than home site (address and tax value) _____

By signing, I certify that all information provided on this application is complete and true to the best of my knowledge. I am aware that providing false information may result in my eligibility being revoked and collection efforts applied to any balances due. I authorize CVMC to verify information and to obtain a Consumer Credit Report as deemed necessary. I also agree to apply for any and all other third-party benefits to which I may be entitled. I agree to notify CVMC if other payer sources are obtained.

Patient/Responsible Party Signature: _____Date: _____

Spouse/Partner Signature: _____ ***Date:*** _____

For Hospital Staff Use Only

Monthly Gross Income: **Total Countable Assets:**
Applicant: $ _____ $ _____
Spouse: $_____
Total: $_____ ESC: _____

Account Number	Date of Service	Service Type	Balance

Reviewed by: _____ **Date**:_____

☐ **Approved:** % Discount ___100% ___80% ___60% ___40% ___20%

☐ **Denied:** Reason _____

Approval:

Coordinator ($50 - $15k) _____ Director ($15k - $30k) _____

Vice President ($30k-$50k) _____ President ($50k+) _____