Albany Community Health Clinic | (307) 766-3313
2710 E Harney Street Suite 202| Laramie, WY 82072

UW Family Practice | (307) 234-6161
1522 E. A St. | Casper, WY 82601

UW Family Medicine | (307) 632-2434
820 E. 17th St. | Cheyenne, WY 82001

Sliding Fee Scale

We appreciate your interest in EHCW's Sliding Fee Program. This program is intended to help those under the 200% FPL, defer some of the out-of-pocket medical expenses for individuals with or without insurance. To qualify, we require that you provide documentation of your household income and complete the attached application. If you wish to apply for a sliding fee discount, please follow the directions below, complete the attached application, and provide the requested documentation. You may qualify for fee reductions retroactively before the date your application is received if the proper documentation is **provided within 15 days**.

Step 1. Fill out the Sliding Fee Application, and you must include all household members and sign your application.
Step 2. Provide proof of your income. Please provide the following documents for each household member (related and unrelated) over the age of 18 to show household income. Members of the household must provide a copy of one or more, as applicable, for income verification:

- **Income Tax Return**- A signed copy of the most recent tax return showing Adjusted Gross Income.
- **Paycheck stubs**- Most recent pay stubs(s) indicating gross pay (Covering the last three months period of work).
- **Agency Letter**- A letter from the Social Security Administration, Veterans Administration, or Social Service Agency (i.e., AFDC, Food Stamps, or WIC) indicating income level.
- **Unemployment Verification**- Paperwork from the Employment Securities Commission (ESC) proving unemployment status and the amount of unemployment compensation received.
- **Court Documents**- Official documents citing child support or alimony as awarded by a judge accompanied by a statement of child support enforcement stating the amount received.
    - In the situation when a patient seeks services and identifies themselves as being separated from their spouse, legal documentation such as a legal separation agreement or divorce filing will be requested from the patient, but not required if self-declared.
- **Official Paperwork**- Paperwork documenting retirement, disability, and SSI benefits.
- **Employer Letter**- A letter from the patient's employer detailing current gross income and frequency of pay periods may be accepted for those not receiving an actual paycheck. Contact information must be provided so that the information can be verified. (Preferably on business letterhead).
- **For patients with no job or other income source**- A letter from an agency, friend, relative, or past employer who knows the situation and is not living with the applicant. The letter must include the writer's name and address (phone number if available) as well as a current or recent date (i.e., not from 2003).
- **Self-declaration**- is acceptable if no other information can be provided; the self-attestation form is to be completed.
- **Minors**- Minors applying for SFDS may declare as a separate household when seeking services for reproductive health. To include, but not limited to, STD testing, pregnancy, birth control, etc.

Step 3. Return your Sliding Fee Application along with the supporting documentation using one of the ways listed below:

- Drop off at any of our Educational Health Center of Wyoming (EHCW) clinics.
- Mail it to any of our clinics listed above, with attention to the Front Office Business Manager.

Step 4. Patient notification of Qualification: Your application will be processed, and you will receive a letter or email (based on the answer to the question on the slide fee application) explaining whether you qualify based on your application. We will contact you by telephone, mail, or email if additional documentation is needed. Please allow up to 10 days to process your application after receiving it.

If it is determined that you do not qualify for our sliding fee program, you will be responsible for any accrued charges. If it is determined that you do qualify for our sliding fee program, a credit will be given if you have overpaid for your clinic visit and have no other outstanding bills.

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Appendix A: Sliding Fee Discount Schedule Eligibility Determination Form

Patient Name:		Date of Birth: / /	
Household Information: (Please list everybody that lives in the patient's household.)			
Patient	Full Name	Account Number (Office Use Only)	Date of Birth
Yes / No			/ /
Yes / No			/ /
Yes / No			/ /
Yes / No			/ /
Yes / No			/ /
Family Size for Slide Calculations			

If necessary, list more household members on back.

Household Income:			
Frequency of Income	Type of Income	Amount of Income	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		Per Month	**Per Year**
Sliding Fee Scale Total Income		$	$

Are you renewing your Sliding Fee Discount? □ No □ Yes *If yes, continue to next questions.*

Has anything prevented you from seeking healthcare in the last 6 months? □ No □ Yes

If yes, what? ______________________________

Do our discounts allow you to receive the healthcare you need? □ No □ Yes

If no, why? ______________________________

Patient Signature: ______________________________ Date:______________________

For office use only: Sliding Fee Scale Honored (circle one) Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	
Length of Sliding Fee Scale Honored:	Slide Expiration Date: / /
Comments:	
Account Number:	Guarantor Account Number:
Approved By :	Date: / /

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Self-Attestation with no Income

The Educational Health Center of Wyoming (EHCW) allows patients to self-attest if they are currently unemployed and/or do not receive income at the time of service. Please fill out the information below to support this Self-Attestation. Failure to answer these questions may result in your application being denied.

1. How long have you been unemployed and/or been without any income?

____

2. What is your current status? ____ Looking for work _____ Applying for disability _____ Temporarily laid-off______ Full-time Student _____ Other: (Please Explain)

____

____

____

3. Do you receive benefits or assistance with living expenses for any of the following? (Check all that apply.)
____ Rent/Housing ____ Energy Assistance ____ Food Stamps (SNAP) ____ Unemployment
____ Friends/Family ____ TANF ____ Churches ____ Non-profit Organization
____ Child Support ____ Student Loans ____ Shelters ____ Other: ____________________

4. If you do not receive assistance from any of the above, how are you paying for basic living expenses? (Ex: Rent, utilities, food, clothing, etc.)

____

____

____

____

I, ____, attest that I currently have no income to report at this time of service for care at EHCW. I understand that should my economic situation change, I am solely responsible for reporting that upon my next visit. All information I provided within this application, including my self-attestation statement, is truthful, correct, and is subject to confirmation by EHCW. Any false statement or perceived attempt to deceive may result in denying sliding fee benefits; any patient balance will be my responsibility.

Signed: ____________________________________Date: ______________