Community Medical Wellness Centers USA®

Sliding Fee Discount Application

It is the policy of CMWC, to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes and must inform us within 30 days of income changes.

Name of Head of Household		Place of Employment		
Home Address	City	State	Zip Code	Phone
Medical Record #:		Date of Service:		

Name	Date of Birth	Name	Date of Birth
Self:		Dependent:	
Spouse:		Dependent:	
Dependent:		Dependent:	
Dependent:		Dependent:	
Dependent:		Dependent:	
Dependent:		Dependent:	

Medi-Cal/Insurance	**YES / NO**	**If you marked yes, please indicate what type/plan it is**
Do you have Medi-Cal or Managed Care Health Plan? Do you have Medicare?		
Other?		

Annual Household Income

Source	Self	Spouse	Other	Total
Gross Wages, Salaries, Tips, etc. Income Tax Return, Paycheck Stub				$
Income from business, self-employment, anddependents. Income Tax Return, Paycheck Stub				$
Unemployment compensation workers' comp, Social Security Income, Public Assistance, Veterans'payments, survivor benefits, pension or retirement income.				$
Interest, dividends, rents, royalties, income fromestates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other misc. income.				$
Self-Declared				$
Total Income	$	$	$	$

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name Print
Signature
Date

Check box and inform patient of the sliding fee percentage/discount they qualify for:

- ☐ 0% Charge 100% Discounts (Slide A)
- ☐ 20% Charge 80% Discounts (Slide B)
- ☐ 40% Charge 60% Discounts (Slide C)
- ☐ 60% Charge 40% Discounts (Slide D)
- ☐ 80% Charge 20% Discounts (Slide E)
- ☐ 100% Charge 0% Discounts (Non-eligible) Full Pay

Reviewed by Supervisor (Print Name): Date: