

# Cheyenne Health and Wellness Center

## Eligibility Determination for Sliding Fee Discounts

Office Use Only: Annual Household Income \_\_\_\_\_ Family Size \_\_\_\_\_  
 Not Eligible For Discounts  
 Sufficient information to verify income? Yes \_\_\_\_\_  
 No \_\_\_\_\_ (complete income verification form)  
 Temporary authorization through \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Six month authorization through \_\_\_\_/\_\_\_\_/\_\_\_\_  
 A  B  C  D

Authorized Signature: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you covered by any of the following forms of insurance?

- a) Private insurance No \_\_\_\_\_ Yes \_\_\_\_\_
- b) Medicare No \_\_\_\_\_ Yes \_\_\_\_\_
- c) Equality Care Card (Medicaid) No \_\_\_\_\_ Yes \_\_\_\_\_
- d) Kid Care /CHIP No \_\_\_\_\_ Yes \_\_\_\_\_

List all other household members by name, gender, birthday, age, and family relationship:

Name:	Sex:	DOB:	Age:	Relationship to Applicant:
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____

Head of Household Social Security Number: \_\_\_\_\_

List all sources of income for each household member and attach recent pay stubs or benefit receipts for at least 4 weeks of pay. Include wages, alimony, child support, veteran's benefits, personal business profits, farm income, seasonal income, disability income, unemployment benefits, social security benefits, pensions/annuities, department of family services benefits, aid to dependent children, food stamps, or any other income.

Amount:	Pay frequency:	Employer or Source of Income:	Paid to:
\$ _____	_____	_____	_____
\$ _____	_____	_____	_____
\$ _____	_____	_____	_____
\$ _____	_____	_____	_____
\$ _____	_____	_____	_____
\$ _____	_____	_____	_____

The information I have provided concerning the size of my household/family and my household/family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge.

I have given this information concerning my financial situation and my means and ability to pay for the purpose of procuring discounts to my own and my household/family's accounts with Cheyenne Health and Wellness. I understand that CHWC will rely on such information to determine applicable discount rate for my account.

**I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the State of Wyoming.**

I agree to report any change in either my income or my family size to CHWC before or at the time of my next contact or any contact by any family member with CHWC. I know that the information I have given will continue to be relied upon until it is changed.

**My signature below indicates that all information I have provided is true to the best of my knowledge. I also am stating that I have no health insurance coverage to pay for any or all of the services I have or will be receiving.**

\_\_\_\_\_  
Signature (Applicant/ Head of Household)

\_\_\_\_\_  
Date