wabash community health center™

Phone: (618)263-4970
Mail: 1001 N. Market Street, Suite 204
Mount Carmel, Illinois 62863

Sliding Fee Discount Application

Patient Information:

Name: _____ Date of Birth: _____

Household Information: List ***all*** individuals living in the home.

Name Date of Birth

1) _____
2) _____
3) _____
4) _____
5) _____

(If more than 5 individuals need listed, please write additional Names/DOB on back side of this application.)

Income Information: Please complete for all adult household members who are employed. Proof of income (income tax return or last 2 paystubs) ***must*** be provided.

Employed person: _____ Type of income: _____

Employed person: _____ Type of income: _____

Employed person: _____ Type of income: _____

(If more than 3 individuals need listed, please write additional Names/type of income on back side of this application.)

Other Income:

Alimony $_____ Child Support $_____ Disability $_____

Pension $_____ Social Security $_____ Unemployment $_____

By signing below, I agree to provide WCHC with proof of income and household size for the purpose of calculating my discount. I understand I will be asked to reapply on an annual basis and agree to inform WCHC if there are changes to my income, household size or insurance coverage. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of service. I understand that, if I fail to submit proof of family size and income, I will be responsible for the full amount of charges. I hereby certify that the information provided is correct.

Applicant signature _____ Date _____

****For Office Use Only****	Person # _____	Effective date _____
Total Income $_____	Discount _____	Staff initials _____