Eagle View Community Health System, Inc.

Confidential Application for Sliding Fee Assistance

Account#
Dental_____
Medical_____

Personal Information

Last Name:_____ First Name:_____ Middle Initial:___

Date of Birth: _____ Sex: _____ Marital Status:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone Number:_____ Social Security Number:_____

Are You: ☐ Employed ☐ Retired

Employment Information

Name of Employer:_____

Address:_____ City:_____ State:_____ Zip:_____

Family Information

Income Includes: (mark documentation used)

☐ AFDC	☐ Social Security	☐ Disability
☐ Pensions	☐ Veteran's Benefits	☐ Wages
☐ Alimony	☐ Child Support	☐ Unemployment
☐ Rents	☐ Interest/Dividends	☐ Educational Asst

☐ Other –Describe _____

Written documentation for all sources of income, for all related family members must be provided. (Non-relatives, such as housemates, do not count.)

Name: _____ Gross Income:_____(year/month/week/bi-weekly)
Please circle one

Name: _____ Gross Income:_____(year/month/week/bi-weekly)
Please circle one

Other Sources of Family Income: _____

Total Annual Gross Family Income: _____

Names and Ages of other Members of the Family:

Name/Age: _____ _____
_____ _____
_____ _____

Insurance Coverage

Do you have any type of insurance coverage?

- ❑ NO
- ❑ YES. *If so, please complete insurance information below*

Name of Insurance Company: _____

The above information is true and correct. I understand this information is subject to review and verification. I understand that I must provide written documentation to support this information. If I do not provide this documentation, or if I have falsified information, my sliding fee eligibility will be terminated. I understand that if I do not return the documentation within 15 days of the office visit, I will be responsible for the charges in full, but future services may have the discount applied. I agree to notify Eagle View Community Health System immediately of any changes in my family income or insurance coverage status. I understand that my discounted co-payment must be paid at the time of service just like the expectations of a private insurance plan.

Applicant Signature: _____ Date: _____

This completed application and supportive documentation must be returned to Eagle View within 15 days of your services received in order to obtain your discount.

Please return application with supporting documentation to:

Eagle View Community Health System, Inc.
Oquawka Location
PO Box 198
Oquawka, Illinois 61469

For EVCHS Office Use Only

Total Family Income: _____

Total Number of Family Members:_____

Eligible Discount Percentage: _____

Date of Expiration: _____

Staff Authorization/Signature: _____ *8/21/15*