Dear Patient,

Our records indicate that you were seen by a provider of The Wright Center for Community Health and you did not have any insurance coverage for the services provided.

If you have insurance coverage, please call the Wright Center for Community Health Billing Department at 570-343-2383 and use option #4. Please provide your insurance information and we will update your file and submit these charges.

If you do not have insurance coverage or have a balance after submission to your insurance that you are unable to pay, you may qualify for the Sliding Fee Discount Program (SFDP). Eligibility is based on self reporting of family income and size. To determine eligibility, please complete the enclosed application. All proof of all income, for each member of your household, will be required for this step. Examples of acceptable proofs of income are listed below, not all may be applicable:

- W-2 Form, most recent pay stubs for the last month of employment
- Letter from employer establishing inc
- Letter from person/persons supplying

Please send your application to:

The Wright Cente
501 South Washir
Scrant
Attention: Outreach and E

You may contact me at 570-591-5253 with a

Thank you for your prompt response.

Desiree Natale
Revenue Cycle Department

# SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name: _____ Date of Reques (e o)-7(e o)-7(e o- A8.(__)-19 (__
e household unit.

(Any person, including yourself, living in household must be listed below):

Name Date of birth

1. _____
2. _____
3. _____
4. _____

| | |
|---|---|
| Child Support | $_____ |
| Military | $_____ |
| VA Benefits | $_____ |
| Pensions/Annuities | $_____ |
| Dividend or Interest Income | $_____ |
| Rental Income | $_____ |
| Total | $_____ |

PROOF OF INCOME IS REQUIRED FOR EACH ADULT MEMBER OF HOUSEHOLD.
Examples of acceptable proof of income are:

- x W-2 Form or most current pay stubs for the last month of employment
- x Current tax return
- x Unemployment, Social security, Disability, Workers' Compensation award letter
- x Child support and/or alimony award letter
- x Pension or retirement income information
- x Letter from employer establishing income
- x Letter from person/persons supplying support showing amount and frequency of support

Does patient currently have any medical insurance? Yes_____ No _____
If yes, please complete the following information: (medical)
Name and Address of Insurance: _____
Policy Number: _____
Policy Holder's Name: _____Date of Birth: _____

Does patient currently have any dental insurance? Yes_____ No _____
If yes, please complete the following information: (dental)
Name and Address of Insurance: _____
Policy Number: _____
Policy Holder's Name: _____Date of Birth: _____

Occupation of Patient: _____

Employer Name: _____

Employer Address: _____

If you had a change in financial circumstance since your last application, please provide documentation of current income or financial status and write a note explaining how it has changed.

_____
_____
_____

I affirm that the above information is true and correct.

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

For Office Use Only

This document was received on _____By _____

Rate approved per table_____ Reapply by _____