WAYNE MEMORIAL COMMUNITY HEALTH CENTERS
A Clinical Affiliate of Wayne Memorial Health System, Inc.

Affordable Healthcare at Wayne Memorial Community Health Centers

No one should go without healthcare because they are not able to pay. That's why Wayne Memorial Community Health Centers offers a Sliding Fee Discount Program (SFDP) to help you afford the cost of your care in our offices. This can also include a Prescription Discount Drug Card (PDDC) to help you afford the medicines that keep you healthy and/or the Family Planning Discount at our Women's Health Offices. These programs are available to all eligible patients based on your family's income.

Income **includes**:

Wages	Unemployment Compensation	Investment Income
Salaries	Net Self-Employment Income	Rental/Royalty Income
Tips	Alimony	Untaxed Foreign Income
Social Security Benefits	Retirement/Pension Income	
Social Security Disability	Capital Gains	

Income **does not** include non-cash benefits such as SNAP, school lunch programs, clothing vouchers, or food/rent you get in exchange for doing a job instead of wages.

Your family size includes you, your spouse and anyone else listed on your tax return.

Find your family size below, is your household income less than the amount listed for the program you need?

Family Size	**Annual Household Income**			**Family Size**	**Annual Household Income**		
	SFDP	Family Planning	PDDC		SFDP	Family Planning	PDDC
1	$30,120	$37,650	$52,710	**5**	$73,160	$91,450	$128,030
2	$40,880	$51,100	$71,540	**6**	$83,920	$104,900	$146,860
3	$51,640	$64,550	$90,370	**7**	$94,680	$118,350	$165,690
4	$62,400	$78,000	$109,200	**8**	$105,440	$131,800	$184,520
For households with more than 8 persons, add $5,380 for each additional person.							

If your income is less than the amount listed in above table, please complete and **sign** the application on the back of this paper. You will also need to give us proof of your income, as explained on the application, within 90 days. If proof of income is not received within 90 days, a new application will need to be completed. We will review the application within 10 business days of receiving **all** required documents.

If you are approved for the Sliding Fee Discount Program, your out-of-pocket cost for services will vary based on income category. Most services are provided with a fee no greater than $30 a visit. Some medical and dental procedures will be a higher cost. The Sliding Fee Discount Program can be used at all sites listed below:

Carbondale Family Health Center • Carbondale Walk- In • Forest City Family Health Center • Hamlin Family Health Center
Highland Physicians Family Health Center • Honesdale Family Health Center • Honesdale Pediatrics
Honesdale Behavioral Health Center • Lake Region Walk In • Northern Wayne Family Health Center • Pike Dental Center
Pike Family Health Center • Pike Pediatrics • Pinnacle Family Health Center • Sterling Pediatrics • Together for Health
Waymart Family Health Center • Waymart Pediatrics • Women's Health Center Carbondale
Women's Health Center Dingmans Ferry • Women's Health Center Hamlin • Women's Health Center Honesdale

If you are approved for the Prescription Discount Drug Card, drug prices vary based on income. The Prescription Discount Drug Card can **only** be used at: Brundage's Pharmacy, Stephen's Pharmacy or Red Cross Pharmacy.

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Sliding Fee Discount Program/Prescription Discount Drug Card Application

Applicant's Name:				Telephone Number:
Address:				Email:
City:	State:	Zip:	Date of Birth:	
Parent/Guardian Name (if different from the applicant):				
How do you prefer to be contacted? ☐ Email ☐ Phone ☐ Mail	When is the best time to contact you? ☐ Morning ☐ Afternoon ☐ Evening		Are you pregnant? ☐ Yes ☐ No	

Are you covered by Medicare, Medicaid, or any other insurance?	☐ Yes	☐ No
Do you currently have prescription drug coverage through insurance?	☐ Yes	☐ No
Are you a patient of Wayne Memorial Community Health Centers?	☐ Yes	☐ No

Type of coverage you are applying for (check all that apply):
☐ Medical ☐ Family Planning (FP) ☐ Dental ☐ Prescription Discount Drug Card (PDDC)

Household Members: List your spouse and anyone who is on your federal income tax return below. Please check yes if any of those people are WMCHC patients and need coverage. Other than your spouse, any household members are not claimed on your tax return will need to apply separately.

Name	Date of Birth	Coverage Needed		If yes, what type (check all that apply)?
1.		☐ Yes	☐ No	☐ Medical ☐ FP ☐ Dental ☐ PDDC
2.		☐ Yes	☐ No	☐ Medical ☐ FP ☐ Dental ☐ PDDC
3.		☐ Yes	☐ No	☐ Medical ☐ FP ☐ Dental ☐ PDDC
4.		☐ Yes	☐ No	☐ Medical ☐ FP ☐ Dental ☐ PDDC
5.		☐ Yes	☐ No	☐ Medical ☐ FP ☐ Dental ☐ PDDC
6.		☐ Yes	☐ No	☐ Medical ☐ FP ☐ Dental ☐ PDDC

What is the total yearly household income (for all people listed above including the applicant), before taxes and some deductions (Line 11 on your tax return)?	$	
Do you file a tax return?	☐ Yes	☐ No
Since your last income tax return, has your income changed drastically?	☐ Yes	☐ No

Applicants must provide a copy of the following documents, if applicable:

- Most recent Federal Tax Return
- Proof of current income (such as 4 weeks of paystubs, bank statements, etc.)

If you have any questions, please call our Outreach and Enrollment Coordinators at 570-251-6569 or 570-251-6554. Completed applications with proof of income can be returned to any WMCHC office, emailed to outreach@wmh.org, faxed to (570) 251-6217 or mailed to:

Wayne Memorial Community Health Centers
Outreach and Enrollment Coordinators
630 Park St. - Honesdale, PA 18431

By signing this application, I certify that the information provided is true and complete and may be checked for accuracy. I understand that purposefully leaving out information and/or providing untrue information on this application will result in denial of this application.

Applicant Signature   Relationship to Patient   Date

Internal use only
Application Status: Date: _____________
☐ Approved (Check all the apply): ☐ Medical ☐ FP ☐ Dental Category: ☐ A ☐ B ☐ C ☐ D ☐ Family Planning ☐ PDDC: ☐ Tier I ☐ Tier II
☐ Denied (Check Reason): ☐ Over Income ☐ Missing Supporting Documents
☐ Pending (Check Reason): ☐ Awaiting Supporting Documents ☐ Other Applications Pending ☐ Awaiting O&E Session
☐ Outreach Attempt #1 Date:________ ☐ LM ☐ No VM ☐ Outreach Attempt #2 Date ________☐ LM ☐ No VM