COASTAL BEND
WELLNESS FOUNDATION
YOUR COMMUNITY HEALTH CENTER

2882 Holly Road
Corpus Christi, Texas 78415
Phone: (361)814-2001

Sliding Scale Program

The sliding fee program allows Coastal Bend Wellness Foundation (CBWF) patients who are uninsured or under-insured to receive healthcare services at a lower cost. We understand it's not always possible for patients to be covered by health insurance, or that insurance may have high deductibles. CBWF offers a sliding fee program to assist patients who may not qualify for public benefits and/or who are not able to afford the full cost of healthcare. An annual grant from the Bureau of Primary Health Care provides the resources which enable us to assist patients who may not otherwise be able to afford their medical care and medications.

The sliding fee program only applies to services provided at Coastal Bend Wellness and Medical (CBWM) facilities. Medication discounts apply only to prescriptions written by CBWM providers. Slide discounts cannot be used at other doctor offices, pharmacies or hospitals.

What services are offered?

- Medical
- Radiology
- Laboratory
- Pharmaceutical
- Behavioral Health

What is required to apply?

- Complete registration packet
- Provide proof of household income or financial assistance
- Household is defined as the applicant + spouse/significant other + their legal tax dependents

How often do I need to apply?

Patients will need to apply for the sliding fee program at least every year. The discounts will typically last 3, 6, or 12 months depending on the patient's unique financial situation. Patients renewing sliding scale eligibility will need to complete a new slide application packet and submit current proof of income before their discount expires. If the discount expires, the patient will have to pay the full charges until a new application packet is processed and approved.

Will I qualify?

See next page for income levels and fees.

COASTAL BEND WELLNESS FOUNDATION Inc.

Medical/Behavioral Health Sliding Fee Schedule

Based on 2022 HHS Federal Poverty Guidelines

Based on Annual Income

% of Poverty	A - 100%		B - 101-133%		C - 134-166%		D - 167-200%		E - Above 200%
Family Size/Income	Above	Below	Above	Below	Above	Below	Above	Below	Above
1	0	$ 13,590	$ 13,591	$ 18,075	$ 18,076	$ 22,559	$ 22,560	$ 27,180	$ 27,180
2	0	$ 18,310	$ 18,311	$ 24,352	$ 24,353	$ 30,395	$ 30,396	$ 36,620	$ 36,620
3	0	$ 23,030	$ 23,031	$ 30,630	$ 30,631	$ 38,230	$ 38,231	$ 46,060	$ 46,060
4	0	$ 27,750	$ 27,751	$ 36,908	$ 36,909	$ 46,065	$ 46,066	$ 55,500	$ 55,500
5	0	$ 32,470	$ 32,471	$ 43,185	$ 43,186	$ 53,900	$ 53,901	$ 64,940	$ 64,940
6	0	$ 37,190	$ 37,191	$ 49,463	$ 49,464	$ 61,735	$ 61,736	$ 74,380	$ 74,380
7	0	$ 41,910	$ 41,911	$ 55,740	$ 55,741	$ 69,571	$ 69,572	$ 83,820	$ 83,820
8*	0	$ 46,630	$ 46,631	$ 62,018	$ 62,019	$ 77,406	$ 77,407	$ 93,260	$ 93,260
	$15 Nominal Charge		75% Discount		50% Discount		25% Discount		0% Discount
* For each additional family member add		$ 4,720		$ 6,278		$ 7,835		$ 9,440	

Based on Monthly Income

% of Poverty	A - 100%		B - 101-133%		C - 134-166%		D -167-200%		E - Above 200%
Family Size/Income	Above	Below	Above	Below	Above	Below	Above	Below	Above
1	0	$ 1,133	$ 1,134	$ 1,506	$ 1,507	$ 1,880	$ 1,881	$ 2,265	2,265.00
2	0	$ 1,526	$ 1,527	$ 2,029	$ 2,030	$ 2,533	$ 2,534	$ 3,052	3,052.00
3	0	$ 1,919	$ 1,920	$ 2,552	$ 2,554	$ 3,186	$ 3,187	$ 3,838	3,838.00
4	0	$ 2,313	$ 2,314	$ 3,076	$ 3,077	$ 3,839	$ 3,840	$ 4,625	4,625.00
5	0	$ 2,706	$ 2,707	$ 3,599	$ 3,600	$ 4,492	$ 4,493	$ 5,412	5,412.00
6	0	$ 3,099	$ 3,100	$ 4,122	$ 4,123	$ 5,145	$ 5,146	$ 6,198	6,198.00
7	0	$ 3,493	$ 3,494	$ 4,645	$ 4,646	$ 5,798	$ 5,799	$ 6,985	6,985.00
8*	0	$ 3,886	$ 3,887	$ 5,168	$ 5,169	$ 6,450	$ 6,452	$ 7,772	7,772.00
	$15 Nominal Charge		75% Discount		50% Discount		25% Discount		0% Discount
* For each additional family member add		$ 393		$ 523		$ 653		$ 787	

Patient pays a nominal $15 fee for Office Visit regardless of income

NO ONE WILL BE DENIED SERVICES FOR INABILITY TO PAY, WE WILL SET UP PAYMENT PLAN WITH PATIENTS

Sliding Fee Program Application

1. Applicant Information

Which office do you go to: ❑ Main Office ❑ Kingsville Clinic **Is this your:** ❑ 1st Time Application ❑ Renewal Application

Name of Responsible Party_____ Date of Birth _____

Address_____ SSN_____

City, State_____ Zip_____ Email_____

Home Phone_____ Cell Phone_____ Work Phone _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow/Widower

Employer_____ Employer's Address _____

Do you have health insurance? ❑ yes ❑ no **Do you have pharmacy insurance?** ❑ yes ❑ no

2. Household Members

Household = Spouse/Significant Other + Tax Dependents

Name (First Last)	Relationship	Date of Birth	SSN	Health Insurance Y or N	Pharmacy Insurance Y or N	Patient at CBWF Y or N	TAX Dependent Y or N

3. Household Income

Household = Spouse/Significant Other + Tax Dependents

Monthly/Annual Income	**YOU** (the Applicant)	Spouse/ Significant Other/	Children (over 18)	Others (Must be tax dependent)
NAME OF EMPLOYER AND EMPLOYER'S ADDRESS				
GROSS Wages, Salaries & Tips	$	$	$	$
Self-Employment or Stmt from Employer	$	$	$	$
Social Security & Disability	$	$	$	$
Supplemental Security Income	$	$	$	$
Workers Comp Benefits	$	$	$	$
Self- Declaration of Income	$	$	$	$
Child Support & Alimony	$	$	$	$
Savings, Interest Income, Pensions	$	$	$	$
Rental Property, Stocks, Dividends, Other				
TOTAL	$	$	$	$

4. Eligibility Information

Do you receive food stamps? ❑ yes ❑ no

Do you receive any public assistance? ❑ yes ❑ no

Did you file a tax return last year? ❑ yes ❑ no

Have you applied for Medicaid? ❑ yes ❑ no

Have you applied for Disability? ❑ yes ❑ no

Do you consider yourself homeless? ❑ yes ❑ no

Do you have health insurance? If so, what kind _____

How much is your Deductible?_____ Do you receive child support or alimony? ❑ yes ❑ no

5. Proof of Income Documents

Attach all items listed below to this

- ❑ **PHOTO ID** - a copy of your driver's license or other photo
- ❑ **PAYSTUBS** - last/previous months paystubs of everyone working in the household OR a "Statement of Income from Employer" form from your employer with GROSS earnings for the previous month.
- ❑ **SELF-EMPLOYED** - complete/sign/date a "Self-Employed Statement" form **AND** make sure to include your Schedule C from your most recent tax return.
- ❑ **BENEFITS/INVESTMENTS/OTHER INCOME** - copies of any benefits checks and/or bank statements for all Investments, Social Security, Disability, Veterans Benefits, Unemployment, Child Support "Paid or Received", Alimony, TANF/AFDC, Military LES, Pensions, Interest payments, etc.
- ❑ **TAX RETURN** - all pages of your most recent tax return.
- ❑ **ZERO INCOME** - applicants with ZERO income must complete/sign/date a "Zero Income/Statement of Personal Assistance" form. If you are living off of savings, will need a copy of your bank or savings account statement.
- ❑ **RELEASE OF INFO/INCOME VERIFICATION** - if receiving public assistance or you have no/limited income, then complete/sign/date the "Release of Info/Income Verification from the DSS" form.

6. Patient Agreement

I certify that all statements contained herein are true and correct and subject to investigation. I authorize the release of employment records and other financial information to an agent of CBWF for sliding fee determination purposes. I understand the following:

- I am responsible for payment of all my copays at the time of service.
- I will notify CBWF of any changes to my income, household size or insurance status.
- I must renew my application to continue receiving the slide discount (at least annually—more if requested).
- Most routine services are covered under the slide discount.
- I understand that if I do not have pharmacy insurance, I may be eligible for pharmacy assistance programs. If eligible, my signature Authorizes CBWF to share medical, eligibility and financial information with pharmaceutical companies or their designees as required for eligibility or audit purposes.

Applicant's Signature:_____ Date: _____

Sliding Fee Program

ZERO Income - *Self Declaration of Income*

I,_____, certify that I have NO source of income.

Name of last employer_____Date of last employment _____

Household/Family Size:_____**HOUSEHOLD = Applicant + Spouse/Significant Other + Legal Tax Dependents**

I am currently:

- ❑ Unemployed – looking for employment. Not receiving unemployment benefits.
- ❑ Seeking Disability. If so, when did you last apply_____? Have you been denied? _____
- ❑ Other _____

I certify that all statements contained herein are true/correct, and subject to investigation. I also authorize the release of employment records and other financial information to an agent of Coastal Wellness and Medical for sliding fee determination purposes.

Signed:_____ Date: _____

Instructions: If you have NO (or limited) income and are receiving help from friends/family, the following must be completed, signed and dated by your benefactors.

Statement of Personal Assistance

I,_____, assist_____(patient) by providing basic living needs listed below:

Food: ❑ Yes ❑ No Relationship to Applicant: _____
Shelter: ❑ Yes ❑ No
Utilities: ❑ Yes ❑ No
Money: ❑ Yes ❑ No Amount $_____

I can be reached to verify this information at:

My Name (Please print): _____
Address: _____
_____
Phone: _____

Signed:_____ Date: _____

Please list any special circumstances on the back of this form

Sliding Fee Program

Self Employed Statement of Income

(Complete this form only if you are self-employed)

Business Name: _____

Business Owner(s): _____

Business Address: _____

_____

Business Phone: _____

Brief Description of Business: _____

_____

_____

GROSS Earnings (FOR THE BUSINESS OWNER = what you paid yourself, *NOT* the business gross)

Need Past (3) Months. Complete below.

Month **20**	**Month** **20**	**Month** **20**
Week 1 $	Week 1 $	Week 1 $
Week 2 $	Week 2 $	Week 2 $
Week 3 $	Week 3 $	Week 3 $
Week 4 $	Week 4 $	Week 4 $
Week 5 $	Week 5 $	Week 5 $
Monthly Total $	**Monthly Total $**	**Monthly Total $**

_____/_____

Signature of Business Owner Date

Sliding Fee Program

Statement of Income from Employer

(Have your Employer complete this form)

To Whom It May Concern:

Your employee,_____, is applying for our Sliding Fee Program (to help with medical expenses). In order to process his/her application, we must have proof of their last/previous month's gross income.

Therefore, please advise us of how much he/she makes per hour, and approximately how many hours he/she works per week.

$_____per hour x_____hours per week (approximately)

OR, if the above isn't practical for your type of business, then please complete the following:

GROSS EARNINGS for last/previous month:

Month:_____20____ $_____

Name of Employer: _____

Direct Supervisor: _____

Address:_____

Phone: _____

_____/_____

Employer's signature Date

Sliding Fee Program

Authorization for Release of Information/ Income Verification from DSS Public Assistance

Applicant's Name (Last, First, Middle Initial) _____

Date of Birth_____ SSN#_____Home Phone _____

Address_____Cell Phone _____

City, State, Zip_____Email_____

County/City of Residence _____

I hereby authorize The Department of Social Services to release information from my file as indicated below to:

Coastal Bend Wellness and Medical
2882 Holly Road.
Corpus Christi, Texas 78415
Fax: (361)814-6502

INFORMATION TO BE RELEASED:

- ❒ Notice of Action
- ❒ Most recent Income Verification
- ❒ SNAP/TANF/WIC/Energy Assistance/etc.
- ❒ Other_____ Any other public assistance programs _____

AUTHORIZATION:

I am applying for the Sliding Fee Program at Coastal Wellness and Medical and understand TACH needs my income/public assistance verification from the Department of Social Services. Therefore, I authorize the above organizations to communicate freely between one another for the purpose of income/assistance verification. I understand this authorization will be valid for 12 months from the date signed. I understand that I may cancel this authorization by sending a written request for cancellation to TACH, and the cancellation will take effect when TACH receives my written notice.

_____ _____

Signature of Applicant/Patient Date

FOR OFFICE USE ONLY

Faxed____/____/___

Form **4506•1**
(September 2018)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t.***

0MB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

Sa If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Coastal Bend Wellness Foundation, 2882 Holly St., Corpus Christi, Texas 78415

Sb Customer file number (if applicable) (see instructions)

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ **1040**

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 11208. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 1O business days 0

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days D

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days D

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests . Most requests will be processed within 1O business days . 0

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 1O years. Information for the current year is generally not available until the year after **it** is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days D

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / **31** / **2018**	I I	I I	I I

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

[a **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions .

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) Date

Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** Date