Cabin Creek Health Systems
Discount Program Application

MRN _____

EXP _____

Patient Name _____ Date of Birth _____

First Middle Last

❍Male ❍Female

Address _____ City/State_____ Zip _____

Social Security # _____ Primary Phone _____ Email _____

State-Issued ID _____ US Resident? ❍Yes ❍No

Household

Number of persons living with you:

Spouse _____ Number of Children _____ Number of Relatives & Others _____

Total Living in Your Household (Including You) _____

List monthly income sources and amounts for **all** people in your household:

Income Source	Gross Amount	Verification Method
1)	$	
2)	$	
3)	$	
Total	$	

Insurance
Do you have any of the following?

Medicare ❍Part A ❍WV Medicaid ❍Private Insurance ❍Other
❍Part B
❍Part C

Read Before Signing (or ask the Financial Assistance Coordinator to read it to you):

I hereby certify that the financial information given by me is correct to the best of my knowledge and belief. I understand that any changes in household income or composition must be reported to the Patient Assistance Office immediately. I understand failure to comply with the above guidelines may result in termination from this program and I will no longer receive the Program Discounts.. The benefits I qualify for have been explained to me and I have had the opportunity to ask questions regarding this program and my discount. All questions have been answered to my satisfaction and I agree to all guidelines regarding this program.

Signature _____ Date _____

For Office Use Only:

Approved By _____
Probably eligible for Medicaid No Yes Patient referred No Yes
Eligible for primary care sliding fee No Yes Sliding Fee Level _____
Verification Date _____ Pharmacy Discount Only _____