Cabin Creek Health Systems
Discount Program Application

MRN_____

EXP_____

Patient Name: _____ Date of Birth: _____

First Middle Last

Gender Identity: ☐ Woman ☐ Man ☐ Transgender ☐ Non-Binary ☐ Prefer not to respond

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

Primary Phone #: _____ Email: _____

US Resident: ☐ YES ☐ NO Social Security #: _____ State Issue ID#: _____

HOUSEHOLD INFORMATION

Number of persons living with you:

Spouse/Partner: _____ # of Children/Dependents*: _____ # of Relatives & Others: _____ **TOTAL in HOUSEHOLD: _____**

Names & Ages of Dependents: _____

_____

List of 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 following?*

Medicare ☐ Part A ☐ Part B ☐ Part C ☐ WV Medicaid ☐ Private Insurance

☐ Other: _____

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 Yes No Patient Referred Yes No

Eligible for primary care sliding fee Yes No Sliding Fee Level_____