Wellness Homes of Chicago
Health Equality - Health Equity - Social Justice - Research

Sliding Fee Discount Program Application

It is the policy of Wellness Homes of Chicago & Wellness Home Behavioral Health Services to provide essential primary care, behavioral health services, and case management services regardless of the individual's ability to pay. We offers discounts through a sliding fee discount program based on household size and annual household income.

Our sliding fee discount program helps make healthcare more affordable for eligible individuals and members of their households. **To apply, please complete and submit this form along with a valid ID and the required proof of income to compliance@wellnesshome.org.** Upon approval for the sliding fee discount program, you must complete this form every 12 months to continue eligibility for discounted services, or sooner if your financial situation changes so we can review your eligibility.

Discounts apply only to comprehensive primary care services at our Halsted & BOY sites, and to case management services and behavioral health services across all service sites as outlined in our policy. *Non-routine primary care and behavioral health services including, but not limited to weight loss programs or other specialized services, certain injections and medications, Transcranial Magnetic Stimulation (TMS), and certain laboratory tests, are excluded from this program. Individuals will be informed when services are not covered under the Sliding Fee Discount Program.*

General Information

Name _____ Date of Birth _____ Phone Number _____

Address _____ City _____ State _____ ZIP _____

Household Size

Household Size is defined as the number of individuals ***living together in the same household, including any children under 18****, and* ***share income and expenses and are dependent on income from other members of the household****.*

Please list all household members, including yourself & those under age 18.

Name	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Total Household Size: _____

Income Verification

Income is defined as the ***total annual amount of money earned or received before taxes for all individuals in the household who share financial responsibility****, including adult children and other household members. This requirement is not applicable to income earned by individuals under the age of 18 unless they are legally emancipated or financially responsible for the household.*

Please tell us how much income you expect to receive over the next year for each applicable person in your household, including all income sources.

Note*: Non-cash benefits such as SNAP (LINK), WIC, or housing vouchers are not counted as income.*

Income Source	Self Annual, pre-tax	Rest of Household Annual, pre-tax	
Gross wages, salaries, tips, etc.	$_____	$_____	
Income from business, self-employment, or freelance work.	$_____	$_____	
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), veterans' payments, survivor benefits, pension, retirement income, and any other government financial assistance received as cash or for basic living expenses.	$_____	$_____	
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources (money received from family/friends, etc).	$_____	$_____	**Total Annual Income for Your Household** **(Pre-tax)**
Annualized Totals:	**$_____**	**$_____**	**$_____**

Please provide the following items to **compliance@wellnesshome.org**:

- ☐ **Proof of income**: For every individual in your household who receives income, please provide the two (2) most recent pay stubs or equivalent proof of income by emailing them to compliance@wellnesshome.org after submitting this application.
- ☐ **Identity Verification**: Please also provide a copy of your driver's license or equivalent form of identification to compliance@wellnesshome.org after submitting this application.

Insurance Information

Please be assured that your insurance status is NOT considered when determining your eligibility for discount. If you have insurance, we will bill it first and apply any discount to what you may still owe.

Do you have insurance? *Please check one:* ☐ Yes ☐ No

If yes, please provide information of your primary & any secondary insurance below.

	Primary Insurance	Secondary Insurance
Insurance Plan Name		
Policy Number		
Group Number		
Subscriber Name		
Subscriber date of birth		
Subscriber relationship to applicant		
Effective date of coverage		

Household and Income Attestation

I hereby certify that the information I have provided is true, accurate, and complete to the best of my knowledge and belief.

Printed Name _____ **Signature** _____ **Date** _____

– OFFICE USE ONLY –

Patient Name: _____ MRN: _____ Approved Discount: _____

Reviewer: _____ Reviewer Signature:_____ Date Reviewed: _____

Verification Checklist	Yes	No
Identification Provided	☐	☐
Proof of Income Provided	☐	☐
Qualifying Tier: ☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ Tier 4 ☐ Tier 5 (not eligible for discount)		

2835 N Sheffield Ave, Chicago, Suite 500, IL 60657 • Tel: 773-296-2400 Ext. 1211 • Fax: 773-296-1097 • compliance@wellnesshome.org