CommunityHealth
& EMERGENCY SERVICES

Cairo Diagnostic Center
13289 Kessler Rd.
Cairo, IL 62914
P: (618) 734-1500
F: (618) 734-9168

Cairo Mega Clinic
13245 Kessler Rd.
Cairo, IL 62914
P: (618) 734-4400
F: (618) 477-8557

Carmi Community Health Center
1400 W. Main St.
Carmi, IL 62821
P: (618) 382-4181
F:(618) 382-3590

Cedar Court Clinic
1340 Cedar Court
Carbondale, IL 62901
P: (618) 457-7821
F: (618) 529-3862

Hardin County Medical
IL Route 146 Bldg. 2
Elizabethtown, IL 62931
P: (618) 285-6191
F: (618) 285-6833

Hardin County Dental
226 Main St
PO Box 69
Rosiclare, IL 62982
P: (618) 285-3930
F: (618) 285-3931

Harrisburg Medical Center
205 N. Main St.
Harrisburg, IL 62946
P: (618) 253-8450
F: (618) 253-8454

Pope County Clinic
217 S. Adams
Golconda, IL 62938
P: (618) 683-3781
F: (618) 683-5802

Pulaski Clinic
100 Market St.
Pulaski, IL 62976
P: (618) 342-6767

Tamms Health Center
290 Railroad St.
Tamms, IL 62988
P: (618) 747-2391
F: (618) 623-0355

Dear Patient/Guarantor:

IMPORTANT: Because we are a Federally Qualified Health Center, we have the opportunity to offer a discount on your services based on your family-size and adjusted gross income. For purposes of determining eligibility for sliding fees, household/family is defined as the number of persons who cohabit, mutually contribute to household expenses and assert that they are a household unit.

This discount is available to all patients who are uninsured or under-insured. This application will help CHESI determine if you are eligible to receive services through our Discounted Sliding Fee Program. If you feel this may be a benefit to you and your family, you will need to complete this application and provide the following documentation.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the clinic in determining whether the patient is eligible for sliding fee.

Please ensure that you return the completed form and submit it in person, by mail, or by fax within 10 business days of receiving this application.

Please understand that in order to receive sliding fee, you will need to show all payment sources such as the following:

- Tax Return
- Paid in Cash-Attestation
- Worker's Compensation
- Income from a period of no less than 30 days
- Social Security/Disability Benefits
- Pension (1099 or letter showing the amount)

- Retirement Benefits
- Trust Fund
- Job Reimbursement
- Life Insurance
- Veteran's Benefits
- Railroad Benefits
- Child support
- Alimony

The following items are **REQUIRED:**

- Proof of Identification for all family members 18 and older who are seeking discount.
- Proof of family size

Optional:

- Attestation – Patients may complete Attestation form to prove family size and income if they meet one of the following criteria:
    - Unemployed adults supported by another adult\
    - Adults who work seasonally or intermittently
    - Adults paid in cash
    - Adults whose only source of income is SSA/Disability benefits
    - Homeless

If you want to submit an appeal of our decision or request reconsideration, it must be in writing. Please include the reason or provide additional information that may be beneficial to our review.

Completion of the application does not relieve you of your financial obligation to Community Health & Emergency Services, Inc.; Community Health & Emergency Services, Inc. reserves the right to deny any application upon review.

EMPLOYEE WAGE FORM

(To be completed and signed by Employer)

Employee Name: _____

Employee Social Security Number: _____

Employer Name: _____

Address: _____

City State Zip Code

Wages for the last 13 Weeks

Week	Pay Period Ending	Gross Wages
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

1. Is the employee currently working? _____ (yes/no), If no, when was the last day of worked? _____
2. If the employee is not currently working, will the employee be returning to work? _____(yes/no) Expected return date: _____
3. When did employment begin: _____ End: _____

I certify the wage information regarding the person named above is true and accurate.

Date: _____

Signature of Employer: _____ Employer Telephone Number: _____

Community Health & Emergency Services, Inc. Sliding Fee Application

Name: _____ Number of members in household? _____

Address: _____
City State Zip Code

Primary Telephone Number: _____ Secondary Telephone Number: _____

SSN: _____ Date of Birth: _____

List of all family members in the household (use additional pages if necessary):

Name	Date of Birth	Social Security Number	Applying for Benefits Yes/No

Income of all family members in household:

Name of Person Receiving Income	Source	Gross Monthly Income
		Total Monthly Income:_____

Did anyone file federal taxes for the previous year? (yes/no) **Name**: _____

By my signature, and to the best of my knowledge, I certify that the information above is true.

Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Internal Use Only: Annual Income:_____ Slide (circle): A B C D E