Dear Patient,

Our records indicate that you were seen by a provider of The Wright Center for Community Health and you did not have any insurance coverage for the services provided.

If you have insurance coverage, please call the Wright Center for Community Health Billing Department at 570-343-2383 and use option #4. Please provide your insurance information and we will update your file and submit these charges.

If you do not have insurance coverage or have a balance after submission to your insurance that you are unable to pay, you may qualify for the Sliding Fee Discount Program (SFDP). Eligibility is based on self reporting of family income and size. To determine eligibility, please complete the enclosed application. All proof of all income, for each member of your household, will be required for this step. Examples of acceptable proofs of income are listed below, not all may be applicable:

- W-2 Form, most recent pay stubs for the last month of employment
- Current tax return
- Unemployment, Social security, Disability, Workers’ Compensation award letter
- Child support and/or alimony award letter
- Pension or retirement income information
- Letter from employer establishing income
- Letter from person/persons supplying support showing amount and frequency of support

Please send your application to:

The Wright Center for Community Health
501 South Washington Avenue, Suite 1000
Scranton, PA 18505
Attention: Outreach and Enrollment Coordinator/Navigator

You may contact me at 570-591-5253 with any questions.

Thank you for your prompt response.

Desiree Natale
Revenue Cycle Department
SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name: __________________________________________________ Date of Request: _______________

Last   First   Middle   Date of Appointment: ___________

Address: __________________________________________________________________________________________

___________________________________________________________________________________________

City      State    Zip Code

Phone Number: (cell) _______________________________    (home) __________________________________

Number of household members living at the above address ___________________________

Family/Household members: The number of persons living in the household, who cohabit, mutually contribute to household expenses and assert that they are a household unit. It is recognized that other persons may reside at the common residence and not be considered as part of the household unit.

(Any person, including yourself, living in household must be listed below):

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
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HOUSEHOLD INCOME (List ALL household income for all adult household members):

Total for 12 months

- Gross Wages, Salaries, Tips $________________________
- Social Security $________________________
- Disability $________________________
- Farm/Self-Employment Net Earnings $________________________
- Unemployment $________________________
- Public Assistance (exclude food stamps) $________________________
- Workers’ Compensation $________________________
- Alimony $________________________
PROOF OF INCOME IS REQUIRED FOR EACH ADULT MEMBER OF HOUSEHOLD.
Examples of acceptable proof of income are:
• W-2 Form or most current pay stubs for the last month of employment
• Current tax return
• Unemployment, Social security, Disability, Workers’ Compensation award letter
• Child support and/or alimony award letter
• Pension or retirement income information
• Letter from employer establishing income
• Letter from person/persons supplying support showing amount and frequency of support

Does patient currently have any medical insurance? Yes__________ No __________
If yes, please complete the following information: (medical)
Name and Address of Insurance: _________________________________________________________________
Policy Number: _______________________________________________________________________________
Policy Holder’s Name: __________________________Date of Birth: __________________________

Does patient currently have any dental insurance? Yes__________ No __________
If yes, please complete the following information: (dental)
Name and Address of Insurance: _________________________________________________________________
Policy Number: _______________________________________________________________________________
Policy Holder’s Name: __________________________Date of Birth: __________________________

Occupation of Patient: _________________________________________________________________________

Employer Name: _____________________________________________________________________________

Employer Address: ____________________________________________________________________________

If you had a change in financial circumstance since your last application, please provide documentation of current income or financial status and write a note explaining how it has changed.
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

I affirm that the above information is true and correct.

_______________________________________________________________             _______________________
Signature of Patient or Guardian       Date

_______________________________________________________________
Relationship to Patient

For Office Use Only

This document was received on ________________________By _______________________________________

Rate approved per table______________________________ Reapply by ________________________________