UNIVERSITY OF WYOMING

Family Medicine Residency Program at Cheyenne
820 East 17th Street • Cheyenne, WY 82001
(307) 632-2434 • fax (307) 634-9295

UWFM Sliding Fee Scale (SFS) Patient Acknowledgement Form

Thank you for choosing the University of Wyoming Family Medicine Clinic as your healthcare provider. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment for services is part of that relationship. To assist you in understanding that financial responsibility, we ask that you read and sign this form. Please feel free to ask if you have any questions.

Patient Responsibilities:

- Upon receiving the UWFM SFS application, you will meet with clinic staff to discuss our financial assistance program.
- You have seven (7) business days to fill out and return your SFS application to UWFM with the required financial documentation.
- Failure or refusal to follow through with providing our office a completed and signed UWFM SFS application will result in no discount and payment in full will be required at the time services are provided.
- If I am approved for a SFS discount, my copay is required at time of service.
- Payment arrangements may be made in advance.
- Failure to comply with your agreed upon payment arrangement with our clinic staff could result in your account being sent for collections.
- UWFM will make every effort to work with you and your financial situation. Case Management may be able to provide you with additional assistance.
- SFS discounts are not all-inclusive. You may be charged per service.
- UWFM accepts cash, personal in-state checks, and VISA and MasterCard credit card payments.

The lab is owned and operated by CRMC. It is important that you apply for CRMC's Financial Assistance Program. Failure to do so may cause delays in tests ordered by your physician.

- **PLEASE NOTE**: There is a $25.00 service charge for returned checks.

I have read, understand, and agree to comply with the UWFM SFS Policies.

UWFM Patient Printed Name	Signature	Date

<<To Be Completed by UWFM Staff Only>>

Patient signed/refused to sign acknowledgement of receipt of the policy.

UWFM Business Office Employee - Signature and Initials _____ _____

Form Effective: October 28, 2020

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Sliding Fee Scale Application

University of Wyoming provides patient care regardless of ability to pay or insurance coverage status. You may be eligible to receive care at a reduced cost through our Sliding Fee Scale program, for which eligibility is based on income and family size.

Required Documentation:

PHOTO IDENTIFICATION

Examples are Driver's license, passport, student ID, etc.

INCOME VERIFICATION

In order to determine where you fall on the sliding fee scale, we must first determine family size and household income. Acceptable ways to document family size and household income may include the following:

- **Most recent tax return**
- If you are unable to provide a copy of your tax return, please complete and attach IRS form 4506-T
- Three months of current pay stubs
- A copy of your current social security benefit award letter,
- A copy of your unemployment benefits letter,
- A copy of your worker's compensation statement
- A copy of your child support award print-out
- A letter from your employer,
- A copy of denied unemployment letter,
- A letter from the Comea Shelter verifying a recent stay at the shelter,
- A letter from the Family Promise program stating you are homeless and in their care,
- A Statement of Self-Declared Income form filled out and signed by the person providing assistance to you and/or your family.

Also provide the name and date of birth of each person who lives in your household, and indicate their relationship to you.

Please return your completed application along with required documents to the office in person, by mail to University of Wyoming Family Medicine at 820 East 17th Street, Cheyenne, WY 82001, or by faxing to (307) 634-3510. If you have any questions or need assistance with this application process, you may contact the office at (307) 632-2434, extension 204.

Client Information

		Date Given:		Acct#	
		Date Received:		Level	Family
				Valid	to

Legal Last Name	First Name, M.I.	Date of Birth	Gender	Social Security #

Physical Address	City	State	Zip	Home Phone	Cell Phone
Mailing Address	**City**	**State**	**Zip**	**Work Phone**	**Message Phone**

Email Address	Marital Status	Race (Circle One)	Ethnicity (Circle One)	Housing Information (Circle One)
		White	Not-Hispanic	
		Asian	Unavailable	
Employment Status (Circle one)	Are you a Veteran?	African American	Decline to Answer	Own Homeless
Employed Retired	Yes / No	American Indian/Alaskan Native	Hispanic/Latino	Rent HUD/CHA
Unemployed Disabled	Are you a U.S. Citizen?	Native Hawaiian/Pacific Islander	Ethnic Black	Rent Free
Self Employed Student	Yes / No	Other/Multi Racial	Decline to Answer	Group Home
			Unavailable	

Employer Name	Employer Phone Number
Employer Address	**Date Hired**

Household Members:

Name	DOB	SS #	Gender	Relationship
Name	**DOB**	**SS #**	**Gender**	**Relationship**
Name	**DOB**	**SS #**	**Gender**	**Relationship**
Name	**DOB**	**SS #**	**Gender**	**Relationship**
Name	**DOB**	**SS #**	**Gender**	**Relationship**
Name	**DOB**	**SS #**	**Gender**	**Relationship**

My signature indicates that all of the information I have provided is true and correct.

Signature of Responsible Party: _____ **Date:** _____

Statement of Self-Declared Income

A. Patient:

a. Please list yourself and the persons in your household (Yourself, spouse and dependents)

_____

_____

_____

b. Have you ever filed an IRS tax return? _____ If yes, when was the last time you filed? _____

*****STOP HERE! THE REST OF THIS FORM NEEDS TO BE COMPLETED BY THE PERSON HELPING YOU FINANCIALLY OR EMPLOYED BY*****

_____

B. Shelter / Nutritional Support:

a. I pay for or furnish shelter for the person(s) listed at the top of this page (Part A):
Yes _____ No _____
   i. If YES, list the address of the shelter or housing provided: _____
      1. How much do you contribute per month? _____
   ii. If NO, who pays for or furnishes shelter? _____

b. I provide food for the person(s) listed at the top of the page: YES _____ NO _____
   i. If NO, how is food purchased? SNAP _____ Food Banks _____ Other _____
   ii. If YES, approximately how much do you contribute for food per month? $_____

c. Is the person listed above as the patient paying rent or utilities? YES _____ NO _____
   i. If YES, how much does the person(s) pay for rent? $_____ Utilities $_____

C. Unemployed:

a. To the best of my knowledge, are any of the people listed in Part A employed?
YES _____ NO _____
   i. If YES, who is employed and where?
      1. Name: _____
      2. Place of Employment: _____

D. Verification of Employment:

a. I employ the following person(s) listed in Part A: _____

b. The employed individual's monthly wage is $_____

I declare under penalty of perjury, that all statements on this form are true to the best of my knowledge.

_____ _____

Signature of person completing this form | Signature of Patient or Legal Guardian

_____ _____

Print Name | Date | Printed Name of Patient

_____ _____

Address | Phone Number | Relationship to Patient

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Community Connect Summary

In order to serve you better, Cheyenne Regional participated in the Laramie County Goal Connect Collaborative. Goal Connect linked multiple agencies together to better serve clients, reduce duplication efforts and decrease gaps in access to the most needed services. Although the Goal Connect database is no longer active, Financial Navigators may continue to share your information with community partners upon your request to assist with your application and eligibility process throughout the community for other assistance programs.

Purpose and Benefits to your Care
We want to better serve your needs through coordinating services. Sharing your individual information may reduce the need for a referral or connect you to public programs and community service groups that may help you. Participating can also reduce repeated paperwork.

You Choose to Participate
We ask you to sign this form which allows Cheyenne Regional Financial Navigators to share your financial assistance application packet with community partners with whom Cheyenne Regional collaborates. It is your choice to sign. No provider may refuse to treat you if you do not sign. If you do not sign the form, Financial Navigators will not share your information. You may cancel your authorization at any time. Cheyenne Regional Financial Navigators do not receive any reimbursement, incentive, referral fees or any other type of monetary, reward, tangible or intangible benefits for such referral.

Security and Privacy Information
Federal and state laws protect the privacy of your information. Financial Navigators will share information via fax upon your request. Financial Navigators comply with HIPAA privacy practices. You will receive the HIPAA notice of Privacy Practices, which gives you the additional information about the provider's respective confidentiality policies.

Current Collaborating Partners are:

- Cheyenne Regional
- HealthWorks
- Peak Wellness Center, Inc.
- Needs, Inc.
- COMEA Shelter
- Community Action of Laramie County - Healthcare for Homeless
- Community Action of Laramie County - Kinship Support Services
- University of Wyoming Family Practice

*** Financial assistance is based upon the individual organization's financial assistance policy. An approval for financial assistance with one organization does not guarantee an approval or a specific level of assistance at all locations.*

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Community Connect Consent Form

- I understand by signing this form, I give permission for a Cheyenne Regional Financial Navigator to share my individually identifiable information with community partners with whom they collaborate.
- I understand that my individual information could include participating in an agency program, demographic information to include name, birth date, gender, race, social security number, address, phone number, household members, financial information, employment status, residential information, health and treatment history and/or personal or family information.
- I have reviewed the list of current collaborating partners, and I know that others may be added later. A list of partners is available to me upon my request.
- I have received a copy of this form.
- I understand that this form will be effective unless I cancel it. I can cancel this authorization at any time by providing a written request.
- I understand if I sign on behalf of someone else, I am certifying that I have authority under Wyoming law to make health care and social services decisions for that person.
- I understand I am allowing a Financial Navigator to share my individual identifiable information with only the collaborating partner(s) listed that I go to for services.
- I understand that this is my choice to sign and that no provider may refuse to treat me if I do not sign.

I have read and understand the above information.

_____	_____
Your Name (Print)	Relationship to Patient
_____	_____
Your Signature (or Representative)	Date
_____	_____
Financial Navigator	Date

Form **4506-T** (June 2019)

Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

► **Do not sign this form unless all applicable lines have been completed.**

► **Request may be rejected if the form is incomplete or illegible.**

► **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ►

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. | / / | / / | / / | / /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

► **Signature** (see instructions) | **Date**

► **Title** (if line 1a above is a corporation, partnership, estate, or trust)

► **Spouse's signature** | **Date**