ComWell
WHERE COMMUNITY MEETS WELLNESS

Sliding Fee Discount Application

It is the policy of ComWell to provide essential services regardless of the individuals ability to pay. Discounts are offered based on family size and annual income.

Please complete the following information and return to the front desk to determine if you or a member of your family are eligible for a discount.

The discount will apply to counseling, psychiatric and substance misuse treatment.

**Services not included in the discount are medications, drug testing, receipt of medical records and other such services.*

ComWell Promises To

- Serve all individuals regardless of ability to pay or geographic location.
- Offer discounted fees for individuals who qualify.
- Not deny services based on an individuals:
  - Age
  - Sex
  - Race
  - Color
  - Religious Belief
  - Ethnic or National Origin
  - Gender Identity
  - Marital Status
  - Physical, Mental or Other Disability
  - Sexual Orientation
  - Native Language
  - Citizenship
  - Genetic Information
  - Pregnancy
  - Any other characteristic protected by law
- Accept Medicare, Medicaid, CHIP and most major insurance plans.

Contact Us

Fax

1.888.388.1971

Red Bud
10257 State Route 3
Red Bud, IL 62278
618.282.6233

Chester
2517 State St
Chester, IL 62233
618.826.4547

Sparta
104 Northtown Dr
Sparta, IL 62286
618.443.3045

Okawville
109 West Elm St
Okawville, IL 62271
618.243.2091

ComWell - Sliding Fee Discount Application

Name of Applicant:_____ Client ID_____ Phone Number:_____

Address: _____

Place of Employment: _____

Relationship to Client: _____

Please list spouse and dependents under age 18:

Self:_____ Date of Birth _____

Spouse:_____ Date of Birth _____

Dependent Name:_____ Date of Birth _____

Dependent Name:_____ Date of Birth _____

Dependent Name:_____ Date of Birth _____

Dependent Name:_____ Date of Birth _____

Annual Household Income: Please provide copies of tax returns, pay stubs or other information verifying income to help us determine eligibility. Determination is not made until documentation is attached.

Source	Self	Spouse	Other	Total
Gross Wages, salaries, tips, etc.				

I certify that the family size and income information shown above is correct:

_____ _____

Signature **Date** **Print Name**

***Please return this form with documentation to your Counselor or Case Manager

For Agency Use ONLY

Note: _____

_____

Approved by: _____ Print Name: _____

Signature/**Title**

Date of Approval:_____ Entered to EHR? ☐Yes ☐No

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ComWell is an equal opportunity provider and employer