CENTER FOR EMOTIONAL HEALTH

Sliding Scale Application

How to complete this application:

1. Review the information of this page very carefully.
2. Complete Parts 1 through 4 of the application.
3. Gather the required documentation below to turn in with your application.
4. Mail, email or fax your complete application and required documentation to the following:

By mail: Attention- Billing Department
280 Executive Park Drive, Suite 100
Concord, NC 28025
By email: billing@cehcharlotte.com
By fax: 704-547-3150

Send all of the following together:

Your completed and signed application with proof of income (Pick two of these options)

1. Copy of last year's federal income tax return
2. Three most recent pay stubs
3. All income statements from jobs last year (W2 or 1099)

Note: Applications can not be reviewed if any documentation is missing. All requirements are listed above in order to successfully complete the application review process.

What happens next?

You will be contacted with a status update of your application submission and/or request for additional/ missing information or documentation that is necessary to complete your application. You will be contacted by either phone or email.

Anyone with commercial insurance that CEH accepts automatically does not qualify for patient assistance. The commercial insurances we currently accept are Blue Cross Blue Shield, Cigna, Aetna and Tricare.

Please allow 3-5 business days for your application to be processed.

CEH reserves the right to refuse assistance to any applicant.

Part 1- Program Eligibility Information:

Applicant Name: _____

Home Address: _____

_____

Email Address: _____

Primary Language spoken (Please circle one): English Spanish Other

Marital status (Please circle one): Married Divorced Single

If you are over 18, are you financially dependent on someone else? (Please circle one)

Yes No

If yes, you must provide their proof of income for this application to be processed.

If Applicant Under 18:

Parent/Guardian's Full Name: _____

Parent/Guardian's Cell Phone: _____

Part 2-Income:

What is your total household gross income? (Include yourself, your spouse and your dependents)
$_____ Monthly OR $_____ Yearly

Household Number (Circle one) 1 2 3 4 5 6 7 8

Place of Employment: _____

Part 3- Insurance:

Do you have insurance coverage? (Please circle one): Yes No

If yes, what insurance do you currently have? _____

Part 4- Consent

I GIVE the program administrator and their employees, agents, and contractors, permission to verify my information to make sure it is true and complete; as well as contact me by phone, email or mail about the program.
Initial _____

I PROMISE that all the information in this application, including my proof my income, is true and complete; I am authorized to sign this application; I will contact the program if any of my information about my insurance coverage or income changes.
Initial _____

I UNDERSTAND that the program will only use my information to decide if I qualify to participate in the program.
Initial _____

I UNDERSTAND that I can call 704-237-4240 (opt 3) at any time to learn more about the program or to withdraw from the program.
Initial _____

I GIVE the program, and the program administrators, permission to contact the person named below with follow up questions about my application. (This only applies of someone completed this application for you.)
Initial _____

Signature of Applicant or Legal Guardian of Applicant:

_____

Date

_____

If someone helped you with this application and you want them to be able to answer questions on behalf of you, please give us their contact information below.

Additional Contact Name _____

Additional Contact Phone Number _____

Additional Contact Email _____