Welvista
Hope and wellness for the uninsured.

121 Greystone Blvd.
Columbia, SC 29210
803-933-9183
www.welvista.org

Before you mail your application, please check each of the following.

Is this a renewal application?	Yes ❑ No ❑
Is each section completed?	Yes ❑ No ❑
Did you sign and date the application?	Yes ❑ No ❑
Did you attach proof of income?	Yes ❑ No ❑
Did you attach proof of your street address?	Yes ❑ No ❑

PATIENT INFORMATION

Last Name: | First: | MI: | Social Security Number ___-___-____ | Birth Date

Patient Address (where you receive your mail) City State Zip

Patient Address (where you live) (attach proof of street address to application) City State Zip

County in South Carolina | Home#/Cell# | Work or alternate#

Ethnic Origin:
Asian ❑ Hispanic ❑
Black ❑ White ❑ Other ❑

Gender:
Male ❑
Female ❑

Are you a legal resident? Yes ❑ No ❑

List all medications you are allergic to. If no allergies, write "NO."

Doctor/Clinic/Healthcare Provider | Doctor/Clinic/Healthcare Provider's#

Circle number of people who live in your household including self:
1 2 3 4 5 6 7 8 9

Do you have (please check) ❑ Health Insurance/Affordable Care Act ❑ Medicare ❑ Medicaid ❑ Family Planning /Healthy Check Up ❑ VA Health
I do not have any medical health insurance ❑

PATIENT ELIGIBILITY INFORMATION

List all household income, gross monthly amounts

Salary/Wages	$ _____
Disability	$ _____
Alimony/Child Support	$ _____
Social Security	$ _____
Pension/Retirement	$ _____
Unemployment/Work Comp	$ _____
Total Gross Household Monthly Income:	$ _____

ATTACH PROOF OF HOUSEHOLD INCOME

Include proof of ALL household income - wages (2 current consecutive paystubs), pension/retirement, social security, SS disability with Notice of Award, child support, alimony, unemployment, worker's compensation, rental income, etc. SEE BACK FOR ADDITIONAL INCOME INFORMATION

AGREEMENT/ DISCLOSURE / RELEASE

I attest that the above information is complete and accurate. By my signature, I authorize the release of the information about me and my medical condition to Welvista and/or their agents. I authorize Welvista and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into the Welvista program, which may include contacting and providing information to social workers, state agencies, healthcare providers or other persons or entities Welvista may deem appropriate to release medical records or required information bearing on my eligibility and benefits under the program. Additionally, I agree that at any time during my enrollment Welvista may request additional documentation to authenticate the statements made on my application. **I will notify Welvista if I become eligible for Medicare, Medicaid, Health Insurance, VA Health Benefits, or if there is a change in my financial status or my mailing address changes.** My signature below indicates that I have opted out of child proof caps. I have received Welvista's Notice of Privacy Practices Statement.

Patient/Guardian signature _____ Date _____

I authorize Welvista to ship my medications to: Authorized clinic or mailing address above _____

WELVISTA USE ONLY

Plan ID _____ AC Health _____

Pt Adv _____ FP# _____

Approval Date _____ Expiration Date _____

Facility _____

DOCTOR/CLINIC USE ONLY

Doctor/Clinic _____

Hospital _____

HOP# _____ HOP ID# _____

Access Health Group _____

Questions? Call 1-803-933-9183 or visit www.welvista.org

Welvista Application Instructions

To Qualify, you:

✔Must be a legal resident of South Carolina

✔Cannot have Medicare, Medicaid (except Family Planning/ Healthy Connections Checkup), VA Health Benefits or Private Health Insurance

✔Household income must be at or below 200% of the Federal Poverty level. Refer to this chart. →

Return completed application, proof of street address, and proof of income for everyone in your home to:

Welvista
121 Greystone Blvd.
Columbia, SC 29210

2016 HHS Federal Poverty Guidlines**
**Gross income before taxes and/or any deductions

# in Household	Monthly Gross Income	Yearly Gross Income
1	$1,980	$23,760
2	$2,670	$32,040
3	$3,360	$40,320
4	$4,050	$48,600
5	$4,740	$56,880
6	$5,430	$65,160
7	$6,122	$73,460
8	$6,815	$81,780
For each additional person add	$693	$8,320

1. PROOF OF PHYSICAL ADDRESS- Provide proof of where you live (street address you listed on the application)

2. PROOF OF INCOME: For each person in your home who has income, attach all of the following items listed below that apply. If you are not sure what to send, call and we will help you.

Job –
- Send 2 recent weeks of pay stubs (within the last 45 days) that are consecutive (with no weeks missing in between) showing your/your household's GROSS income (with any deductions listed), not NET. We cannot accept copies of checks or bank statements.
- You may instead send a signed and dated letter from your/your household's employer stating what work is done, if there are any deductions from pay, the GROSS rate of pay, and the number of hours worked for the last 2 weeks. You may send a completed copy of Welvista's Employer Statement of Income.

Commission –Please send 1 month of documentation stating commission earnings.

Odd jobs/work for family, friends or neighbors – Send a signed and dated letter from those you/your household do work for stating what work is done, the GROSS rate of pay (with any deductions listed), and the number of hours worked for the last 2 weeks.

Self-employed – Send your/your household's most recent Federal 1040 tax return and the Schedule C – Business Profit or Loss worksheet or you may send a completed copy of Welvista's Self Declaration of Income Form. Call Welvista if you need this form.

Unemployment – Send Unemployment Benefit Statement showing the weekly amount received as well as the benefit-year-end date (BYE). It must be clear you are currently receiving benefits. We cannot accept copies of checks.

Social Security Retirement/Social Security Disability – Send the Social Security New Benefit Amount letter showing MONTHLY amount received for the CURRENT year. **If you are the person applying and you receive social security disability you must also send your Notice of Award or entitlement letter from Social Security that shows the month and year you became entitled to disability.** You must be within the first two years of disability when you do not qualify for Medicare. We cannot accept copies of checks or bank statements.

Other Retirement/Pension/Annuity – Send the current benefit statement showing the monthly amount received with any deductions OR a copy of Form 1099. We cannot accept copies of checks or bank statements.

Child Support/Alimony – Send a copy of a current statement from the clerk of court or a copy of the entire divorce decree stating amount received and how often.

No Income – If no one in your home has any income, submit a fully completed No Income form. We need to know how you are paying for your housing, food, and utilities. The person providing support cannot live in same household as the patient. Call Welvista if you need this form.

NOTE: Welvista enrollment is for up to one (1) year. Once approved, you will be eligible for any medications on our current drug list. Medications will be shipped from our pharmacy in Columbia to the address indicated on your application.

If you have any questions or need further assistance, please call 803-933-9183, between 8:30am and 5:00pm EST, Monday through Friday, or visit our website at www.welvista.org.
ALLOW 2 WEEKS TO PROCESS YOUR APPLICATION.