COMMUNITY HEALTH

MEDICAL • DENTAL • BEHAVIORAL HEALTH

CHECK ONE: □ COMMUNITY HEALTH ALLEN POND
□ COMMUNITY HEALTH BRANDON
□ COMMUNITY HEALTH CASTLETON
□ COMMUNITY HEALTH METTOWEE
□ COMMUNITY HEALTH PEDIATRICS
□ COMMUNITY HEALTH RUTLAND
□ COMMUNITY HEALTH SHOREWELL
□ COMMUNITY HEALTH PHARMACY BRANDON

ENROLLED BY: _____

Applicant's Name: _____ Application Date: _____ / _____ / _____

Applicants Address: _____ Phone #: _____

_____

Your enrollment in our sliding fee scale cannot be completed until all check items are received.
Please return these items by _____ / _____ / _____.

PROOF OF IDENTITY/DATE OF BIRTH AND RESIDENCE: YOU MUST SHOW ONE OF THE DOCUMENTS LISTED IN BOTH CATEGORIES. PHOTOCOPIES ARE ACCEPTABLE

Identity/Date of Birth
- Driver's license/Official photo ID
- Passport
- Baptismal or other Religious Certificate
- Official school records
- Adoption records
- Official hospital/doctor birth records
- Naturalization certificate
- Marriage records
- Immigration Documents

Residency/Home Address
- ID card with address
- Postmarked envelope, postcard or magazine (cannot use if sent to a PO Box)
- Driver's license issued with the last 6 months
- Utility bill (gas, electric, cable), bank statement, correspondence from a government agency which contains name and street address
- Letter/lease/rent receipt with home address from landlord
- Property tax records or mortgage statement

PROOF OF CURRENT INCOME AND EXPENSES: YOU MUST PROVIDE A LETTER, WRITTEN STATEMENT, OR COPY OF CHECK STUBS, FROM THE EMPLOYER, PERSON OR AGENCY PROVIDING THE INCOME. SUBMIT ALL THAT APPLY. PROVIDE THE MOST RECENT PROOF OF INCOME BEFORE TAXES. THE PROOF MUST BE DATED, INCLUDE THE EMPLOYEE'S NAME AND SHOW GROSS INCOME FOR THE PAY PERIOD.

Wages and salary
- Paycheck stubs (4 consecutive weeks)
- Letter from employer on company letterhead, signed and dated
- Income tax return / W2

Self Employed
- Signed and dated income tax return and all schedules
- Records of earnings and expenses

Unemployment Benefits
- Award letter/certificate
- Benefit check
- Correspondence from Dept. of Labor

Public Assistance
- Rental Assistance $_____
- Heating Assistance $_____

Social Security
- Award letter/certificate
- Benefit check
- Correspondence from Social Security Adm.

Child Support / Alimony
- Letter from person providing support
- Letter from court
- Child support/alimony check stub

Worker's Comp
- Award letter
- Check stub

Veteran's Benefits
- Award letter
- Benefit check stub
- Correspondence from Veteran's Adm.

Military Pay
- Award letter
- Check stub

Income from Rent
- Letter from tenant
- Check stub

Interest/Dividends/ Royalties
- Statement from bank, credit union, or financial institution
- Letter from broker
- Letter from agent

Private Pensions and Annuities
- Statement from pension/annuity

Dependent Care Costs
- Written statement from day care center or other child/adult care provider
- Cancelled checks or receipts

***** W-2'S OR INCOME TAX RETURNS FOR OTHER THAN SELF-EMPLOYED MAY BE USED FOR APPLICATIONS PRIOR TO APRIL 6TH OF THE FOLLOWING YEAR. IF LATER, YOU MUST INCLUDE ANOTHER FORM OF DOCUMENTATION.***

CONTACT INFORMATION:

First Name:	Middle Initial:	Last Name:	
Please give us a phone number where you can be reached if we need to contact you.	Phone #:	Secondary Phone #:	
Home address:	Street:	Apt #:	
	City: / State:	Zip Code:	County:
Mailing Address: (if different)	Street:	Apt #:	
	City: / State:	Zip Code:	County:

HOUSEHOLD INFORMATION: List the head of household in line 1. List the name of spouse or significant other on Line 2 List the names of dependent children on lines 2-10.

	Name: First, Middle Initial, Last	Date of Birth	Sex: F/M	Relationship to Head of Household	Social Security Number
1				Head of Household	
2					
3					
4					
5					
6					
7					
8					

By signing my name below, I attest that all of these statements are true and that I do not have access to other medical insurance through the federal government, the state, an employer or on my own. I also understand that I am applying to VT / NY Medicaid before I can be approved for the Community Health Sliding Fee Scale.

_____ _____ / _____ / _____

(Signature of guarantor) *(date)*

INCOME

Total value of income: (make copies for file)	$			
Family size				
We have received a copy of the Medicaid denial letter. ***If patient has previously applied for Medicaid with the last 6 months, we will accept that denial letter***.	o Yes	o No	Date of letter: ___/___/___	
Qualifies for Sliding Fee Scale	o Yes		o No	
% of slide	o 100%	o 90%	o 80%	o 70%

Approved By:_____ Date: _____ / _____ / _____

Updated 10/1/21 MP