**Sliding Fee Assistance Application**

communitydental@chcrr.org **Fax: 802-774-5042 Rutland P: 802-774-5050 Shoreham P: 802-897-7716**

Date:___________________________

Patients Name: ___________________________________Date of Birth:________________________

Address:__________________________________________________State:_________Zip:_________

Email: _____________________________________________________

Daytime Phone: _________________________________ Cell:__________________________

Number of members in your household: Adults: _______ Children: _______

Name:____________________ Employer:______________________ Gross monthly income:__________

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Please circle: Do you or your family receive Food Stamps? **Yes** or **No** Amount $__________

Housing Assistance? **Yes** or **No** Amount $ _________, Fuel Assistance? **Yes** or **No** Amount $_________

Child support / Alimony? **Yes** or **No** Amount $_________ If **Yes** provide written proof each benefit.

Welfare Benefits? Amount $__________________Unemployment? Amount $ _____________________

VT Medicaid? **Yes** or **No** **If no, please provide a denial of eligibility within 30 days of applying to this application. To apply or request a denial form from Medicaid call 1-855-899-9600**

**INCOME for EACH member of the household: (Please provide copies of last 4 PAY STUBS, Last year income tax return, W-2 previous year, or if collecting Social Security or Disability, Welfare, Unemployment or copy of IRS form 1040.)** Please list any additional income if any for you or any other household member:

1.________________________________________________________________________________

2.________________________________________________________________________________

**Sliding Fee Application checklist:**

- Income for the household(see above): including 3 squares proof of benefits (food stamps, housing, fuel)
- Photo ID for person applying
- Proof of address (piece of mail)
- If you are self-employed please provide last year's tax returns
- Must be on Medicaid or have a denial letter to be eligible for assistance
  To request a denial from Medicaid call 1-855-899-9600

**Office Use Only:**

Total Income_______________ Family Size_____________ Medicaid______Denial________

Slide Level 100% 90% 80% 70% Self Pay

Signature_________________________________ Date_________________