



COMMUNITY HEALTH

MEDICAL • DENTAL • BEHAVIORAL HEALTH

CHCRR.ORG

LOCATION – CHECK ONE

- | | |
|--|--|
| <input type="checkbox"/> Community Health Allen Pond | <input type="checkbox"/> Community Health North Main |
| <input type="checkbox"/> Community Health Brandon | <input type="checkbox"/> Community Health Pediatrics |
| <input type="checkbox"/> Community Health Castleton | <input type="checkbox"/> Community Health Rutland |
| <input type="checkbox"/> Community Health Dental | <input type="checkbox"/> Community Health Shorewell |
| <input type="checkbox"/> Community Health Mettowee | <input type="checkbox"/> Community Health Pharmacy Brandon |

ENROLLED BY: _____

Sliding Fee Scale Application

Applicant's Name: _____ Application Date: _____

Applicant's Address: _____ Phone #: _____

Your enrollment in our Sliding Fee Scale Application cannot be completed until all checked items are received. Please return these items by _____.

Proof of Identity, Date of Birth and Residence –

You will be required to show one of the documents listed in both categories below. 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 (Note: cannot use if sent to a PO Box)
- Driver's license issued within the last 6 months
- Utility bill (gas, electric, cable), bank statement, correspondence from a government agency that contains name and street address
- Letter / lease / rent receipt with home address from landlord
- Property tax records or mortgage statement

Proof of Current Income & Expenses – You will be required to 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.

Wage & Salary

- Paycheck stubs – four (4) consecutive weeks
- Letter from employer on company letterhead – signed and dated
- Income tax return / W-2

Social Security

- Award letter/certificate
- Benefit check
- Correspondence from Social Security Administration

Military Pay

- Award letter
- Check stub

Self-Employed

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

Child Support / Alimony

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

Income from Rent

- Letter from tenant
- Check stub

Unemployment Benefits

- Award letter / certificate
- Benefit check
- Correspondence from Department of Labor

Worker's Compensation

- Award letter
- Check stub

Interest / Dividends / Royalties

- Statement from bank, credit union, or financial institution
- Letter from broker
- Letter from agent

Public Assistance Benefit Letters

- Rental \$ _____
- Heating \$ _____

Veteran's Benefits

- Award letter
- Benefit check stub
- Correspondence from VA

Private Pensions & Annuities

- Statement from pension / annuity

Dependent Care Costs

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

Please Note → W2's or Income Tax Return for other than self-employed may be used for applications prior to April 6 or the following year. If later, you must include another form of documentation.

Contact Information →		For Applicant			
First Name:		Middle Initial:		Last Name:	
Contact Phone Number(s):		Primary 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 → Line 1 = Head of household. Line 2 = Name of spouse or significant other (S.O.).
Lines 2 through 10 = List names of dependent children.

Name = First / Middle Initial / Last	Date of Birth	Sex: F/M	Relationship to Head of Household	Social Security Number
1.			Head of Household	
2.			Spouse or S.O.	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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 \$ _____ <i>(Make copies for file)</i>	Family Size = _____
We have received a copy of the Medicaid denial letter. <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Letter: _____		
<i>Note: If patient has previously applied for Medicaid within the last six (6) months, we will accept that denial letter.</i>		
Qualifies for Sliding Fee Scale: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Percent (%) of Slide:		
Medical/Dental /BH: <input type="checkbox"/> 100% <input type="checkbox"/> 90% <input type="checkbox"/> 80% <input type="checkbox"/> 70% Pharmacy: <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 5% <input type="checkbox"/> 25%		

Approved by: _____ Date: _____