COMMUNITY HEALTH
MEDICAL • DENTAL • BEHAVIORAL HEALTH

CHCRR.ORG

**LOCATION – CHECK ONE**

- ☐ Community Health Allen Pond
- ☐ Community Health Brandon
- ☐ Community Health Castleton
- ☐ Community Health Dental
- ☐ Community Health Mettowee
- ☐ Community Health North Main
- ☐ Community Health Pediatrics
- ☐ Community Health Rutland
- ☐ Community Health Shorewell
- ☐ 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

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 Department of Labor

Public Assistance Benefits

- ❒ Rental Assistance
- ❒ Heating Assistance

Social Security

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

Child Support / Alimony

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

Worker's Compensation

- ❒ Award letter
- ❒ Check stub

Veteran's Benefits

- ❒ Award letter
- ❒ Benefit check stub
- ❒ Correspondence from VA

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 & 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 $ _____ *(Make copies for file)* | Family Size = _____ |
|---|---|---|
| We have received a copy of the Medicaid denial letter. ❒ Yes ❒ No Date of Letter: _____ *Note: If patient has previously applied for Medicaid within the last six (6) months, we will accept that denial letter.* | | |
| Qualifies for Sliding Feel Scale: ❒ Yes ❒ No | | |
| **Percent (%) of Slide:** **Medical/Dental/BH:** ❒ 100% ❒ 90% ❒ 80% ❒ 70% **Pharmacy:** ❒ 100% ❒ 75% ❒ 50% ❒ 25% | | |

Approved by: _____ Date: _____