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 Program Application

Contact Information				Date / /
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:

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
- ❒ Immigration documents

Residency/Home Address
- ❒ Postmarked envelope, postcard or magazine (Note: cannot use if sent to a PO Box)
- ❒ Driver's license issued within the last 6 months or ID card
- ❒ Letter / lease / rent receipt with home address from landlord

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

Social Security/Supplemental SS
- ❒ Award letter/certificate
- ❒ Correspondence from Social Security Administration

Worker's Compensation
- ❒ Check stub

Veteran's Benefits
- ❒ Award letter
- ❒ Correspondence from VA

Rental Income
- ❒ Letter from tenant

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

Private Pensions & Annuities
- ❒ Statement from pension / annuity

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 →	If Different than 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 (Optional)	Income
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: ________________

For Office Use Only

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 Fee Program: ❒ Yes ❒ No		
Percent (%) of Slide: **Medical/Dental/BH:** ❒ 100% ❒ 90% ❒ 80% ❒ 70% **Pharmacy:** ❒ 100% ❒ 75% ❒ 50% ❒ 25%		

Approved by: ______________________________ Date: ________________