



Application for Sliding Fee Discount

1. Applicant

Name (Last) _____ (First) _____ (MI) _____
 Street Address _____ City _____ State _____ Zip _____
 Home Phone _____ Date of Birth _____ SS# _____
 Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

2. Household Members

(Spouse/Dependent Children/Relatives/Other)

Name	Relationship	Birth Date	Social Security #
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

Have you applied for State Health Care Y N Are you homeless? / Doubling up? Y N
 Results _____ Do you live/work in Chittenden County? Y N
 Are you a College/University student? Y N What is your Citizenship Status? _____
 If yes, Can you be claimed as a dependent on someone else's tax return? Y N
 (If Yes, additional income verification required)

3. Total Income of Family

(Anyone on your income tax return)

Income Calculation

1. Total Household Members

From Sections 1 & 2 _____ Wages/Salary \$ _____ per _____ = \$ _____
 Self-employment \$ _____ per _____ = \$ _____

2. Total Annual Income

\$ _____ Unearned \$ _____ per _____ = \$ _____
 (Specify type) _____

4. Insurance

Do you or your spouse have dental insurance coverage? Y N

Company _____

Do you or your spouse have health insurance benefits? Y N

Company _____

5. SIGNATURE

To the best of my knowledge, the above information is true and correct. I agree to inform the Center of any changes in my employment or financial status. If the above information proves to be incorrect, I understand that the discount provided to me will be terminated. (I also give permission for the Health Center staff to contact my employer or any other source to verify income.)

Signature of Applicant

Date

FOR CENTER USE ONLY

Auth. Initials _____ Slide Level _____ Approval/Denial Date _____ Renewal Date _____