



Application for Sliding-Fee Discount and Homeless Healthcare Program

Phone: (802) 264-8124

Fax: (802) 540-0165

www.chcb.org

patientsupport@chcb.org

1. Applicant

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

2. Tax Household Members *(Who would be listed on your tax return documents. Please include all household members on one form.)*

Name	Relationship on Taxes	CHCB Patient? (Y/N)	Birth Date	Social Security #
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				

3. Are you a College/University student? Yes No (If "Yes" you will need to supply a copy of your FAFSA to apply.)
 Can you be claimed as a dependent on someone else's tax return? Yes No
(If yes, additional income verification is required)

3a) Are you homeless? Yes No Transitional Housing

3b) If yes, please describe: _____

3c) Where are you staying? _____

3d) How long will you be staying there? _____

3e) Are you aware of homeless services in our community? Yes No

4. Total Tax Household Income Total

(Tax filers and all dependents)

Total Household Members	Wages/Salary	\$ _____ per _____	= \$ _____
From Sections 1 & 2 _____	Self-employment	\$ _____ per _____	= \$ _____
	Unearned	\$ _____ per _____	= \$ _____
Total Annual Gross Income	\$ _____		

5. Self-Declaration of Income

Self-Declaration: I declare that I have been working and receiving payments in cash in the amount of \$ _____ per _____. I have no pay stubs or other documentation to prove my earnings.

Self-Declaration: I, declare that I have no employment and do not have income of any kind. **(If you choose this option please explain how you pay for basic expenses including housing, food and utilities.)**

6. Insurance

Do you or your spouse have dental insurance coverage? Yes No Company _____

Do you or your spouse have health insurance benefits? Yes No Company _____

If yes, is it a Vermont Health Connect Policy? Yes No

Insured - Insurance Provider:

Uninsured

Filled out State Insurance Application (Green Mountain Care)

Application pending/Called GMC with patient to check application status

Do you have a medical and dental provider?

Yes Medical Provider Name: _____

No

Yes Dental Provider Name: _____

No Dental Provider

Are you interested in receiving information about any of the following community services?

Medical

Dental

Counseling Food Shelf Housing

Would you like us to connect you with services today? Yes No

7. Signature

By signing below I give permission to the Community Health Centers of Burlington, Inc. (CHCB) to share this document and any attachments thereto with University of Vermont Medical Center (UVMCMC) for the purposes of enrollment in its sliding fee schedule. I understand this sharing of information may decrease any out-of-pocket cost to me for services ordered at CHCB but performed at UVMCMC (e.g. laboratory testing). I also understand that I may revoke this permission if CHCB has not yet acted in reliance on it by writing 'do not share with UVMCMC next to my signature and that signing this document is not a condition of receiving treatment at CHCB or UVMCMC.

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, financial status or housing. 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.)

It is expected that all patients will be forthright and honest about their medical coverage and financial information. Intentional omission or falsification of identity, financial, or demographic information is fraud and may result in dismissal from the practice for up to one year. In the event of falsification, the patient will be responsible for the full payment of services.

Signature of Applicant

Date

FOR CENTER USE ONLY

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

Please return this form with one of the following forms of income verification to patientsupport@chcb.org:

- 2 consecutive paystubs from the last 30 days
- Social Security, disability or pension benefits statements
- IRS Form W2 or 1099
- FAFSA form **(If you are a student you will also need this document.)**
- Most recently filed tax return **(form 1040)**