Community Health Centers

Application for Sliding-Fee Discount
Homeless Healthcare Program

Phone: (802) 264-8124 Fax: (802) 540-0165 www.chcb.org patientsupport@chcb.org

1. Applicant

Name (Last)_____(First)_____(Middle Initial)_____

Street Address_____City_____State_____Zip_____

Home Phone_____Date of Birth_____ Social Security Number_____

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	CHC 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 Free Application for Federal Student Aid [FAFSA] to apply.)

Can you be claimed as dependent on someone else's tax return? ☐ Yes ☐ No

(If yes, additional proof of income will be required)

3a) Are you experiencing homelessness? ☐ Yes ☐ No (*If yes, please check appropriate box below)*

3b) ☐ Doubling up or living with others ☐ Shelter ☐ Street ☐ Transitional Housing

3c) Where and how long will you be staying there? _____

3e) Are you aware of community services for those experiencing homelessness in our community? ☐ Yes ☐ No

4. Total Taxable Household Income

(Tax filers and all dependents)

Total Household Members

From Sections 1 & 2_____

Wages/Salary $_____per_____= $_____

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

1. $_____ per _____ ☐ Week ☐ Month ☐ Year

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 Insurance Company: _____

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

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

☐ Insured - Insurance Provider: _____

☐ No medical or dental insurance coverage

☐ Filled out State Insurance Application (Green Mountain Care [GMC])

☐ Application pending/Called GMC with patient to check application status

7. Do you have a medical and dental provider?

☐ Yes, Medical Provider Name: _____

☐ No health care coverage.

☐ Yes, Dental Provider Name: _____

☐ No dental coverage.

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 these services today? ☐ Yes ☐ No

8. Signature

By signing below, I give permission to the Community Health Centers of Burlington, Inc. (CHC) to share this document and any attachments thereto with University of Vermont Medical Center (UVMMC) 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 CHC but performed at UVMMC (e.g., laboratory testing). I also understand that I may revoke this permission if CHC has not yet acted in reliance on it by writing 'do not share with UVMMC next to my signature below and that signing this document is not a condition of receiving treatment at CHC or UVMMC.

To the best of my knowledge, the above information is true and correct. I agree to inform the Health 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.)

Patients are expected to provide accurate information about their medical coverage and financial information. Intention-al 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.

_____

Signature of Applicant **Date**

FOR OFFICE 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 benefitsstatements
- IRS Form W2 or 1099
- FAFSA form (**if you are a student, you will also need to provide this document)**
- Most recently filed tax return (form 1040)