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)

Community Health Centers

Arjiga Qiimo Dhimista Ka Dhaafitaanka Bilaashka ah ee Barnaamijka Daryeelka Caafimaadka Guriga

Taleefanka: (802) 264-8124 Faakiska: (802) 540-0165 www.chcb.org patientsupport@chcb.org

1. Dalbadaha

Magaca (Awowga)_____(Kowaad)_____(Xarafka Kowaad ee Magaca Aabaha)_____

Cinwaanka Jidka_____Magaalada_____Gobolka_____Boosta_____

Taleefanka Guriga_____Taariikhda Dhalashada_____ Lambarka Sooshaal Sekuuritiga_____

Kali_____Xaas Leh_____Kala Tagay_____Kala Maqan_____Carmal_____

2. Cashuurta Xubanaha Qoyska *(Yaa ku qoran liiska waraaqahaaga cashuur celinta. Fadlan waxa aad ku dartaa dhamaan xubnaha qoyska hal foom)*

	Magaca	Xidhiidhka Texas	Bukaanka CHC? (H/M)	Taariikhda Dhalashada	Lambarka Sooshaal Sekuuritiga
1.					
2.					
3.					
4.					
5.					

3. Ma waxa aad tahay arday Kuuliyad/Jaamacad? ☐ Haa ☐ Maya (Hadii "Haa" ay tahay waa inaad keentaa nuqulka Arjiga Bilaashka ah ee Kaalmada Ardayga Federalka [FAFSA] si aad u dalbato.)

Miyaad dalban kartaa ruuxa isaga oo aad ka masuul tahay cashuur celinta? ☐ Haa ☐ Maya

(Hadii ay haa tahay, cadayn dheeraad ah oo dakhliga ah ayaa loo baahan yahay)

3a) Ma waxa aad tahay bilaa guri? ☐ Haa ☐ Maya (*Hadii ay haa tahay, fadlan waxa aad saxdaa sanduuqa hoos)*

3b) ☐ Dul saar ku ah ama la nool qof kale ☐ Hoy ☐ Jidka ☐ Guri Kala Guur

3c) Halkee iyo mudo intee le'eg ayaad joogtay halkaas? _____

3e) Miyaad la socotaa adeegyada bulshada ee loogu talo geley dadka la kulma bilaa guriga ee bulshadaada? ☐ Haa ☐ Maya

4. Wadarta Dakhliga Qoyska La Cashuurayo

(Filterka cashuurta iyo dhamaan cida laga masuulka yahay)

Wadarta Xubnaha Qoyska
Laga Bilaabo Qaybta 1 & 2_____

Gudana/Mushaharka $_____= $_____
Is u shaqaysta $_____= $_____
Aan la helin $_____= $_____

Wadarta Dakhliga Sanadkii $_____

5. Bayaaminta Dakhliga

☐ Bayaaminta: Waxa aan bayaaminayaa in aan shaqeeyay oo aan la heley lacag cadaan ah oo xadigeedu dhan yahay
1. $_____ _____ ☐ Todobaadkii ☐ Bishii ☐ Sanadkii

Ma hayo waraaqo mushahar ah ama waraaqo kale oo aan ku cadayn karo dakhligayga.

☐ Bayaaminta: Waxa aan bayaaminayaa in aanan haysan shaqo oo aanay isoo gelin wax dakhli ahi. **(**Hadii **aad doorato ikhtiyaarkan, fadlan waxa sida aad iskaga bixiso kharashaadkaaga aas aasiga ah oo ay ku jiraan guryaynta, cuntada iyo adeegyada.)**

5. Caymiska

Miyaad adiga ama xaaskaagu leedahay caymiska daryeelka ilkaha?
☐ Haa ☐ Ma Lihi Shirkad Caymis: _____

Miyaad adiga ama xaaskaagu leedahay caymiska daryeelka caafimaadka?
☐ Haa ☐ Ma Lihi Shirkad Caymis: _____

Hadii haa ay tahay, ma waxaa weeye caymiska Vermont Health Connect Policy? ☐ Haa ☐ Maya

☐ Ka Caymiman - Bixiyaha Caymiska:

☐ Ma lihi caymis caafimaadka ama daryeelka ilkaha ah

☐ Buuxi Arjiga Caymiska Gobolka (Green Mountain Care [GMC])

☐ Arji la sugayo/Loo yaqaan GMC oo leh barnaamij ay ka eegaan bukaanku

Miyaad haysataa bixiye caafimaadka ama daryeelka ilkaha ah?

☐ Haa, Magaca Bixiyaha Caafimaadka: _____

☐ Maya, ma lihi caymiska caafimaadka ama daryeelka ilkaha ah. _____

☐ Haa, Magaca Bixiyaha Daryeelka Ilkaha: _____

☐ Maya, Ma Lihi Daryeelka Ilkaha

Ma doonaysaa inaad hesho macluumaadka ku saabsan wixii adeegyada bulshada ee soo socda ah?

☐ Caafimaadka

☐ Daryeelka ilkaha

☐ Latalinta ☐ Cuntada Diyaarsan ☐ Guryayn

Miyaad doonaysaa in aanu kugu xidhno adeegyadan maanta? ☐ Haa ☐ Maya

6. Saxeexa

Marka aan saxeexo hoos, waxa aan u ogolaanayaa Community Health Centers of Burlington, Inc. (CHC) inay la wadaagto waraaqahan iyo wixii lfaaq ah ee University of Vermont Medical Center (UVMMC) oo ujeedadoodu tahay in aan ku biiro jadwalka bilaashka ah. Waxa aan fahansanahay in wadaagista macluumaadkan uu kordhin karo kharashka jeebka ka baxaya ee adeegyada lagu armay CHC laakiin ay fulinayso UVMMC (sida, shaybaadhka laabka). Waxa aan sidoo kale fahansanahay in aan ka noqon karo ogolaanshahahn hadii CHC ayna weli adeegsan aniga oo qoraya hala wadaagina UVMMC meesha ku xigta saxeexa hoose oo saxeexida waraaqahan uma aha shardi daawaynta CHC ama UVMMC.

Ilaa inta aan ogahay, macluumaadka sare waa run oo waa sax. Waxa aan ogolaaday in aan u sheego Xarunta Caafimaadka wixii isbedel ah ee shaqadayda, xaaladayda dhaqaale ama guryayntayda ah. Hadii macluumaadka sare la ogaado inuu khaldan yahay, waxa aan fahansanahay in qiimo dhimista la i siinayo la joojin doono. (Waxa aan sidoo kale ogolaanshahayga siiyay shaqaalaha Xarunta Caafimaadka inay la xidhiidhaan cida aan u shaqeeyo ama meelaha kale ee dakhligu iga soo galo si ay u xaqiijiyaan dakhligayga.)

Bukaanka waxaa looga fadhiyaa inay keenaan macluumaad sax ah oo ku saabsan caymiskooda iyo macluumaadkooda dhaqaale. Uga reebida u kaska ah ee macluumaadka ama been ka sheegida aqoonsiga, dhaqaalaha ama macluumaadka shakhsi ahaaneed waxaa weeye khiyaano oo waxay keeni kartaa in la iska joojiyo nidaamka ilaa hal sano. Hadii uu been ka sheego, bukaanka ayaa ka masuul ah oo bixin doona lacagta oo dhamaystiran.

_____

Saxeexa Dalbadaha **Taariikhda**

KALIYA isticmaalka xafiiska CHC
Auth. Xarfaha magaca ee hore ___ Heerka Dhaaafinta _____ Ansixinta/Taariikhda Daryeelka Ilkaha _____ Taariikhda Cusboonaysiinta _____

Fadlan kusoo celi foomkan oo la socda mid kami dah foomamka soo scoda ee xaqiijinta dakhliga patientsupport@chcb.org:

- 2 waraaqood oo mushahar ah oo xidhiidh ah oo 30 maalmood ee lasoo dhaafay ah
- Bayaanka gunooyinka Sooshaal Sekuurigiga, laxaad la'aanta ama hawlgabka.
- Foomka IRS ee W2 ama 1099
- Arjiga FAFSA **(hadii aad tahay arday, waxa aad sidoo kale u baahan tahay inaad keento waraaqaha)**
- Cashuur celinta ugu danbaysay ee la xareeyay (foomka 1040)