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

Maombi ya Punguzo la Ada ya Unafuu wa Huduma
Programu ya Huduma ya Afya kwa Wasio na Makazi

Simu: (802) 264-8124 Faksi: (802) 540-0165 www.chcb.org patientsupport@chcb.org

1. Mwombaji

Jina (La Mwisho)_____(La Kwanza)_____(Kifupisho cha kati)_____

Anwani ya Mtaa_____Jiji_____Jimbo_____Zip_____

Simu ya Nyumbani_____Tarehe ya Kuzaliwa _____ Namba ya Hifadhi ya Jamii_____

Sijaoa/Sijaolewa____Nimeoa/Nimeolewa____Tumetalikiana_____Tumetengana_____Mjane_____

2. Walipakodi katika Kaya *(Nani watakaooreshwa katika hati zako za ritani ya kodi. Tafadhali wajumuishe wanakaya wote katika fomu moja.)*

	Jina	Uhusiano kwenye Kodi	Mgonjwa wa CHC? (Ndiyo/Hapana)	Tarehe ya Kuzaliwa	Hifadhi ya Jamii #
1.					
2.					
3.					
4.					
5.					

3. Je, wewe ni mwanafunzi wa Chuo/Chuo Kikuu? ☐ Ndiyo ☐ Hapana (Kama "Ndiyo" utapaswa kuwasilisha nakala za Maombi yako ya Bila Malipo ya Msaada wa Wanafunzi wa Serikali Kuu [FAFSA] ili kuomba.)

Je, unaweza kudaiwa kuwa tegemezi kwenye ritani ya kodi ya mtu mwingine? ☐Ndiyo ☐ Hapana
(Kama ndio, uthibitisho wa ziada wa mapato utahitajika)

3a) Je, unakabiliwa na ukosefu wa makazi? ☐ Ndiyo ☐ Hapana (*Kama ndiyo, tafadhali tiki kisanduku sahihi hapa chini)*

3b) ☐ Unaishi na watu wengine ☐ Makazi ☐ Mtaa ☐ Makazi ya Mpito

3c) Wapi na muda gani utakuwa unaishi hapo?_____

3e) Je, unazifahamu huduma za jamii kwa wale wanaokabiliwa na ukosefu wa makazi katika jamii yetu? ☐ Ndiyo ☐ Hapana

4. Jumla ya Mapato ya Kaya Yanayotozwa Kodi
(Walipa kodi na tegemezi wote)

Jumla ya Wanakaya
Kutoka Sehemu ya 1 & 2_____

Ujira/Mshahara $_____kwa_____= $_____
Kujiajiri $_____kwa_____= $_____
Isiyostahili $_____kwa_____= $_____

Jumla ya Mapato ya Mwaka $_____

5. Tamko Binafsi la Mapato

☐ Tamko Binafsi: Ninatangaza kuwa nimekuwa nikifanya kazi na kupokea malipo ya pesa taslimu kiasi cha
1. $_____ kwa _____ ☐ Wiki ☐ Mwezi ☐ Mwaka

Sina hati ya malipo au nyaraka zingine kuthibitisha mapato yangu.

☐ Tamko Binafsi: Ninatangaza kuwa sina ajira na sina mapato ya aina yoyote. **(Ukichagua chaguo hili, tafadhali eleza jinsi unavyolipia gharama za msingi ikiwemo nyumba, chakula na huduma za umma.)**

_____

5. Bima

Je, wewe au mwenza wako ana bima ya afya? ☐ Ndiyo ☐ Hakuna Kampuni ya Bima:
Je, wewe au mwenza wako ana mafao ya bima ya afya? ☐ Ndiyo ☐ Hakuna Kampuni ya Bima:
Kama ndiyo, je, ni Sera ya Vermont Health Connect? ☐ Ndiyo ☐ Hapana

☐ Nimelipiwa Bima - Mtoa Huduma za Bima:
☐ Hakuna bima ya matibabu wala ya meno
☐ Nimejaza Maombi ya Bima ya Jimbo (Green Mountain Care [GMC])
☐ Maombi yanasubiri/GMC walipigiwa simu na mgonjwa kuangalia hali ya ombi

Je, una mtoa huduma ya afya na matibabu ya meno?

☐ Ndiyo, Jina la Mtoa Huduma ya matibabu: _____

☐ Hapana, Bima ya Afya au Matibabu ya Meno. _____
☐ Ndiyo, Jina la Mtoa Huduma ya Matibabu ya Meno:_____

☐ Hapana, Mtoa Huduma ya Matibabu ya Meno

Je, umevutiwa kupokea taarifa kuhusu huduma zozote kati ya zifuatazo za jamii?

☐ Matibabu
☐ Huduma ya Meno
☐ Ushauri ☐ Rafu za Chakula ☐ Nyumba

Je, ungependa tuwasiliane nawe kuhusu huduma hizi leo? ☐ Ndiyo ☐ Hapana

6. Sahihi

Kwa kusaini hapa chini, ninatoa ruhusa kwa Vituo vya Afya vya Jamii vya Burlington, Inc. (CHC) kukipatia Chuo Kikuu cha Tiba cha Vermont (UVMMC) hati hii na viambatisho vyovyote ulivyoweka kwa madhumuni ya uandikishaji katika ratiba yake ya programu ya unafuu wa ada za huduma. Ninaelewa kuwa kutoa taarifa hii kunaweza kunipunguzia gharama yoyote kutoka mfukoni mwangu kwa ajili ya huduma zilizoagizwa katika CHC lakini zikafanywa katika UVMMC (kwa mfano, vipimo vya maabara). Pia ninaelewa kwamba ninaweza kuondoa ruhusa hii kwa ikiwa CHC bado haijafanya kazi kwa kutegemea ruhusa hiyo kwa kuandika 'usitoe kwa UVMMC pembeni ya sahihi yangu hapo chini na kwamba kusaini hati hii sio sharti la kupata matibabu CHC au UVMMC.

Taarifa ya hapo juu ni ya kweli na sahihi, kadri ya ufahamu wangu. Ninakubali kukijulisha Kituo cha Afya kuhusu mabadiliko yoyote ya hali yangu ya ajira, kifedha au makazi. Ikiwa taarifa za hapo juu zitathibitika kuwa sio sahihi, ninaelewa kuwa punguzo nililopewa litasitishwa. (Pia natoa ruhusa kwa wafanyakazi wa kituo cha Afya kuwasiliana na mwajiri wangu au chanzo kingine chochote ili kuthibitisha mapato.)

Wagonjwa wanatarajiwa kutoa taarifa sahihi kuhusu bima zao za afya na taarifa za kifedha. Kuondoa au kughushi kwa makusudi taarifa za utambulisho, kifedha, au demografia ni ulaghai na kunaweza kusababisha kuondolewa kwenye programu hadi mwaka mmoja. Iwapo kutakuwa na taarifa ghushi, mgonjwa atapaswa kulipa malipo yote.

_____

Sahihi ya Mwombaji **Tarehe**

Kwa matumizi ya ofisi ya CHC TU
Vifupisho vya Mwandishi_____ Kiwango cha Unafuu _____ Tarehe Ya Kukubali/Kukataa _____ Tarehe ya Kuhuwisha _____

Tafadhali rudisha fomu hii na fomu mojawapo ya uthibitisho wa mapato kati ya zifuatazo kwa patientsupport@chcb.org:

- hati 2 za malipo zinazofuatana zilizotolewa siku 30 zilizopita
- Taarifa za hifadhi ya jamii, ulemavu au mafao ya uzeeni.
- IRS Form W2 au 1099
- Maombi ya FAFSA **(iwapo wewe ni mwanafunzi, unapaswa kuleta hati hii)**
- Ritani ya kodi iliyowasilishwa hivi karibuni (fomu 1040)
  tarehe 06/06/23.