



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) _____ (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? _____

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

4. Monthly Income From:

Gross Salary Wages	\$ _____	\$ _____
Self Employed	\$ _____	\$ _____
Unemployed	\$ _____	\$ _____
Workmans' Compensation	\$ _____	\$ _____
Disability	\$ _____	\$ _____
Social Security	\$ _____	\$ _____
Retirement/Pension Income	\$ _____	\$ _____
Interest/Investment Income	\$ _____	\$ _____
Divided Income	\$ _____	\$ _____
Alimony/Child Support	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
VA Benefit	\$ _____	\$ _____
Other: _____		

5. Self-Declaration of Income

Self-Declaration: I declare that I have been working and receiving payments in cash in the amount of

\$ _____ 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 (UVMCC) 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 UVMCC (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 UVMCC next to my signature below and that signing this document is not a condition of receiving treatment at CHC or UVMCC.

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. 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.

Signature of Applicant

Date

FOR OFFICE USE ONLY

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

Please return this form with two 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 to provide this document)
- Most recently filed tax return (form 1040)