community health centers OF BURLINGTON

Application for Sliding-Fee Discount and Homeless Healthcare Program

Phone: (802) 264-8124 Fax: (802) 860-4311 www.chcb.org

1. Applicant

Name (Last)_____(First)_____(MI) _____

Street Address_____City_____State____Zip_____

Phone Number_____ Date of Birth_____ SS#_____

Single_____Married_____Divorced_____Separated_____Widowed_____

2. Household Members *(Spouse/Dependent Children/Relatives)*

	Name	Relationship	Birth Date	Social Security #
1.				
2.				
3.				
4.				
5.				

3. Are you a College/University student? ☐ Yes ☐ No

Can you be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
(If yes, additional income verification is required)

Are you in the United States on a non-immigrant visa such as, student, tourist or governmental delegation? ☐ Yes ☐ No

Are you homeless? ☐ Yes ☐ No

If yes, please describe: _____

Where are you staying? _____

How long will you be staying there? _____

Are you aware of homeless services in our community? ☐ Yes ☐ No

4. Total Family Income

(Anyone on your income tax return)

Total Household Members

From Sections 1 & 2_____

Total Annual Income $_____

Income Calculation

Wages/Salary $_____per_____= $_____

Self-employment $_____per_____= $_____

Unearned $_____per_____= $_____

(Specify type) _____

5. 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 Medical Provider

☐ Yes Dental Provider Name: _____

☐ No Dental Provider

Are you interested 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

6. 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 (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 CHCB but performed at UVMMC (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 UVMMC next to my signature and that signing this document is not a condition of receiving treatment at CHCB or UVMMC.

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 _____

Revised 12.6.17 CRD