



# Application for Sliding-Fee Discount and Homeless Healthcare Program

Phone: (802) 264-8124

Fax: (802) 860-4311

www.chcb.org

patientsupport@chcb.org

## 1. Applicant

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
 Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

## 2. Household Members (Spouse/Dependent Children/Relatives/Other)

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 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)

Income Calculation

**Total Household Members** Wages/Salary \$ \_\_\_\_\_ per \_\_\_\_\_ = \$ \_\_\_\_\_

From Sections 1 & 2 \_\_\_\_\_ Self-employment \$ \_\_\_\_\_ per \_\_\_\_\_ = \$ \_\_\_\_\_

Unearned \$ \_\_\_\_\_ per \_\_\_\_\_ = \$ \_\_\_\_\_

**Total Annual Income** \$ \_\_\_\_\_ (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

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

**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 \_\_\_\_\_

Please return this form with one of the following forms of income verification to [patientsupport@chcb.org](mailto: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
- Most recently filed tax return (form 1040)
- Unemployment benefits statement