



61 Pine Street  
 Bristol, VT  
 Phone (802) 453-5028 Fax (802) 453-6105

## Sliding Fee Discount Program Application Form

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Previous Name (if applicable): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address (if different than above): \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_



### Sections 1 through 8 must be completed.

1. **Marital Status:**  Married  Single  Divorced  Partner  Widowed  Legally Separated

2. **Employment Status:**  Full-Time  Part-Time  Self-Employed  Military  Unemployed

3. **Student Status:**  Full-time Student  Part-time Student  Not a Student

4. **Do you, or the patient you represent, have medical/dental insurance?**  Yes  No

• If yes, list insurances:

Insurance Company Name: \_\_\_\_\_ ID# \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ ID# \_\_\_\_\_

• If No, have you applied for Vermont Medicaid?  Yes  No

5. **Do you need assistance with applying for Vermont Medicaid?**  Yes  No

6. **Household Information:** List yourself and all other members of your household which are listed as dependents on your income tax return. Roommates who share mutual living expenses are not considered to be members of the same household.

Name	Relationship	Birth Date	Social Security #	Yearly Income
	SELF			



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**7. Documents Provided for Proof of Income:** *check all that apply*

- |  |  |
|--|--|
| <input type="checkbox"/> Child Support                     | <input type="checkbox"/> Supplemental Security Income (SSI)              |
| <input type="checkbox"/> Disability                        | <input type="checkbox"/> Tax Return Form #1040 (Line 9) (total income)   |
| <input type="checkbox"/> Letter from Employer              | <input type="checkbox"/> Tax Return Form #1040SR (Line 9) (total income) |
| <input type="checkbox"/> Pay stubs (minimum 2 pay periods) | <input type="checkbox"/> Unemployment                                    |
| <input type="checkbox"/> Pension/Retirement                | <input type="checkbox"/> W2 Tax Form                                     |
| <input type="checkbox"/> Social Security                   | <input type="checkbox"/> Workers Compensation                            |
| <input type="checkbox"/> Social Security Disability        | <input type="checkbox"/> Other _____                                     |

If no members of your household earn income used to calculate eligibility for the sliding fee scale, please check the box below and appropriate box within Means of Support.

I attest that all members of my household have **NO INCOME**

**8. If you Attest to NO INCOME,** please describe the means of support below:

I agree to pay my copay at the time of services and any out-of-pocket balances owed (after insurances are billed and SFDP discounts have been applied). I agree to inform MHC if there are changes to my household income, household size, or insurance coverage. I will be asked to reapply for the program on an annual basis. By signing below, I agree the income information provided with this application are true and correct and will be used for purposes of calculating my sliding fee discount.

\_\_\_\_\_  
**Signature of Patient/Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Patient/Guardian Name**

\_\_\_\_\_  
**Relationship to Patient**