Mountain Community Health

61 Pine Street
Bristol, VT
Phone (802) 453-3911 Dental Care Fax (802) 453-3983 Primary Care 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*

- ☐ Child Support
- ☐ Disability
- ☐ Letter from Employer
- ☐ Pay stubs (minimum 2 pay periods)
- ☐ Pension/Retirement
- ☐ Social Security
- ☐ Social Security Disability
- ☐ Supplemental Security Income (SSI)
- ☐ Tax Return Form #1040 (Line 9) (total income)
- ☐ Tax Return Form #1040SR (Line 9) (total income)
- ☐ Unemployment
- ☐ W2 Tax Form
- ☐ Workers Compensation
- ☐ 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**