



61 Pine Street • Bristol, VT 05443 • Phone (802) 453-3911 • Medical Fax (802) 453-6105 • Dental Fax (802) 453-3983

### Sliding Fee Discount Program Application

#### Why we ask for this information

Mountain Community Health (MCH) offers a Sliding Fee Discount Program to help make care more affordable. To determine whether you qualify and what discount you may receive, we are required to review household size and household income. Your answers are used only to determine eligibility and the discount level. You will not be denied services because you are unable to pay.

*Please complete Sections 1–8. Incomplete forms may delay your discount determination.*

#### Section 1. Patient Information

<b>First Name:</b>	<b>Middle:</b>	<b>Last Name:</b>
<hr/>		
<b>Previous Name (if applicable):</b>		
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<b>Date of Birth (MM/DD/YYYY):</b>	<b>Social Security #:</b>	
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<b>Preferred Phone Number(s):</b>	<b>Email:</b>	
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<b>Mailing Address:</b>	<b>City/State/ZIP:</b>	
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<b>Physical Address (if different):</b>	<b>City/State/ZIP:</b>	
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#### Section 2. Household & Status Information

Marital Status:  Married  Single  Divorced  Partnered  Widowed  Legally Separated

Employment Status:  Full-Time  Part-Time  Self-Employed  Military  Unemployed

Student Status:  Full-Time Student  Part-Time Student  Not a Student

#### Section 3. Insurance Information

Do you (or the patient you represent) have medical and/or dental insurance?  Yes  No

If yes, list insurance(s):

<b>Insurance Company Name:</b>	<b>Member/ID #</b>
<hr/>	<hr/>
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<hr/>	<hr/>
<b>Insurance Company Name:</b>	<b>Member/ID #</b>
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If no, have you applied for Vermont Medicaid?  Yes  No

Do you need help applying for Vermont Medicaid?  Yes  No

**Section 4. Household Members**

List yourself and ALL household members who are claimed as dependents on your federal income tax return. Roommates who do not share financial responsibility are not considered part of the same household.

Name	Relationship	Date of Birth (MM/DD/YYYY):	Annual Gross Income
	Self		

**Section 5. Proof of Income (check all that apply)**

- Most recent federal tax return (Form 1040 or 1040-SR)
- Two consecutive pay stubs (within the last 30 days)
- Social Security or SSI award letter
- Unemployment benefits documentation
- Pension/retirement income documentation
- Other: \_\_\_\_\_

**Section 6. If No One in the Household Has Income**

- I attest that no one in my household currently has income.

If checked, please describe how basic needs are being met (for example: support from family/friends, savings, housing support, public assistance, etc.):

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**Section 7. Program Terms**

- Discounts apply to in-scope services with distinct fees, according to MCH’s sliding fee discount schedule.
- You may be asked to update this application periodically and at least annually.
- If your income, household size, or insurance changes, please notify MCH as soon as possible.
- You are responsible for paying any required copay/nominal fee at the time of service and any balances owed after insurance and discounts are applied.

**Section 8. Patient Acknowledgment and Attestation**

I certify that the information provided on this application is true and accurate to the best of my knowledge and may be used to determine my eligibility for the Sliding Fee Discount Program.

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**Signature of Patient/Guardian**

**Date**

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**Printed Name**

**Relationship to Patient (if not self)**

For office use only: Eligibility Determination Date: \_\_\_\_\_ Pay Class: \_\_\_\_\_

Staff Initials: \_\_\_\_\_