Choptank Community Health Systems, Inc.

Sliding Fee Application

Name: _____ Date: _____

Mailing Address: _____
P.O. Box or Street Town State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Have you enrolled in this program before? _____ Yes _____ No

_____ Have you completed a Medical Assistance application? Results: ☐ Applied ☐ Pending ☐ Denied

_____ I have Health Insurance through _____
(If you have health insurance, we will bill your insurance carrier and apply the discount to any balance due.)

_____ I have no Health Insurance

HOUSEHOLD INCOME

Please list ALL MEMBERS of your household (including yourself). Include those who contribute to the household income and all persons for whom you are financially responsible or those you can claim on your taxes.

Name	Birth Date	Relationship to Applicant	Type of Income (from below)

TYPE OF INCOME STATUS DOCUMENTATION REQUIRED

***Written verification for each source of income is required within 30 days in order to process your sliding fee application. Without verification, your account will not be discounted; $95 is expected prior to receiving services. Income verification must include GROSS INCOME. Acceptable forms of written income verification include:**

EMPLOYED
Prior year Federal tax return
Weekly – Four consecutive pay stubs
Bi-Weekly – Two consecutive pay stubs

SELF EMPLOYED
Most recent Federal tax

DISABILITY
Business Income – Most recent Federal Business
And personal tax returns

UNEMPLOYED
Unemployment Claim determination letter

RETIREMENT
Social Security checks or bank statements showing direct deposits, official documents showing private pension, annuities, or individual retirement accounts

INTEREST/DIVIDENDS
Bank and/or investment account statements

CHILD SUPPORT/ALIMONY
Legal documents showing amounts ordered to be paid for support and/or alimony

Social Security disability checks or bank statements showing deposit, private long or short term disability insurance

OTHER
Any other form of income not stated above

NO INCOME IS RECEIVED*
No income is received from any source- -Zero Income Form

RESPONSIBILITIES AND TERMS OF SERVICE

I certify that all information is true and complete to the best of my knowledge. I understand that any false information of family size and/or financial information may result in loss of eligibility for all household members. I fully understand that I am responsible for medical, dental and/or laboratory services until written verification of income is provided for each household member listed above.

_____ _____

Applicant Signature Date

CHOPTANK community health

see how healthy you can be!

Choptank Community Health System, Inc.
Sliding Fee Scale Program Patient Agreement

I agree that the following has been explained to me and that I will follow ALL the guidelines of this program. I understand that:

1. Only services that are medically necessary and ordered by staff of CCHS are covered under this program.

2. Employment, school and sports physicals are not covered under this program if the fees are paid by the employer, school or team.

3. Some in-office procedures may not be covered by this program. If the service is not covered, the Site Director will assist you to make payment arrangements.

4. Only laboratory services that are performed in our office are covered under this program. Pending sliding fee applications do not qualify for labs; and pathology is not covered under the SFS program.

5. This program does not pay for hospital services of any kind, and does not pay for any service that is not ordered by our staff and performed by our staff in our office.

6. The effective date of my participation in this program is decided by CCHS. Your enrollment is generally good for one year.

7. I agree to notify CCHS if my income level or number of people in my household changes before it is time for renewal of my/our participation in the program.

8. I understand that I am required to bring all documentation for proof of income for the household. I understand that the staff of CCHS may request verification of income at any time during my/our participation in the program.

9. I understand that I may be referred to one of CCHS's Patient Service Coordinators (PSC) for evaluation and assistance. I also understand that by submitting an In-Kind Statement as proof of income, I will be required to meet with a PSC within 30 days of submitting the application. Failure to meet with a PSC may result in termination of the sliding fee discount.

10. Payment of sliding fee scale fees is required at the time the service is received.

Signature_____ Date_____

Print Name: _____ Date of Birth: _____