Choptank Community Health Systems, Inc

Sliding Fee Application

Patient Name: _____ Date of Birth: _____

ZERO INCOME

PLEASE COMPLETE THIS SECTION ONLY IF YOU HAVE NO SOURCE OF INCOME

Name of last employer: _____ Date of last employment: _____

Please explain how your basic needs have been met:

Food: _____

Utilities: _____

Shelter: _____

The following information must be filled out by the person with whom you are living.

Date: _____

This is to confirm that _____ is living at my house / apartment.

_____ S/he currently pays me: $_____ per _____.

_____ S/he is unable to make payments at this time as s/he does not have any income.

_____

Street Address *City/Town* *State* *Zip*

_____ _____

Telephone *Alternate Telephone*

I understand that I must inform Choptank Community Health Systems, Inc. of any changes within ten days. By signing this statement, I also understand that any misrepresentation of the information that I provide to Choptank Community Health Systems, Inc. is considered to be a federal fraud punishable by law, including fines and/or imprisonment.

_____ _____

Printed Name of person patient is living with *Signature of person patient is living with* *Date*

_____ _____

Printed Name of Patient *Signature of Patient* *Date*