CHOPTANK community health
see how healthy you can be!

**Choptank Office: _____**

# Sliding Fee Application

**Name: _____ Date: _____**

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

**Home Phone: _____ Cell Phone: _____ Email: _____**

_____ 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) |
|---|---|---|---|
| | | ***Self*** | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## 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 deposit 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
Form 1040 (not Schedule C)-Most recent
Federal Business &Personal Tax Returns
Cash Payment Verification for Healthcare Form

### Unemployed
Unemployment Claim Determination Letter

### Disability
Social Security Award letter (current year)

### Retirement
Social Security Award letter (current year)
Pension Documentation

### Child Support/Alimony
Legal documents showing amount received for support

### No Income is Received
No income is received from any source-Zero Income Form
Bank Statement

### Other
Any form of income not listed on this 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

☐ Application Declined

**Choptank Office: _____**

Sliding Fee Discount Program

**Patient Agreement**

I agree that the following has been explained to me:

1. Only services that are medically necessary and ordered and performed 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. Laboratory services that are performed in the medical site are covered under the Sliding Fee Discount Program and must be sent to. LabCorp. Pending sliding fee applications do not qualify for labs.

4. This program has limited coverage for radiology services. This program does not pay for inpatient or emergency room services of any kind.

5. Lab fees for dentures and crowns are not eligible for a discount with the Sliding Fee Discount Program. Lab fees for dentures and crowns are determined by actual cost.

6. Cost of long-acting removable contraception not covered.

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

8. 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.

9. I understand that I am required to bring documentation for proof of income for the persons listed on my application. I understand that the staff of CCHS may request verification of income at any time during my/our participation in the program.

10. All income is subject to verification.

11. I understand that I may be referred to one of CCHS's Community Health Workers (CWS) for assistance in determining their eligibility in additional programs.

12. Payment of sliding fee discount fee is required at the time the service is received.

Signature_____ Date_____

Print Name: _____ Date of Birth: _____

**Choptank Office:** _____

Sliding Fee Discount Program

## Program Assessment

Your feedback can help Choptank Community Health better meet your needs. Please tell us how we can improve:

1. **Which Services do you currently utilize at Choptank?**
    a. Medical
    b. Dental
    c. Behavioral Health
    d. Medical & Dental
    e. Medical, Dental and Behavioral Health

2. **Are you able to afford the "office visit fee" charged during your latest Choptank visit?**
    a. Yes
    b. No

3. **The "office visit" fee (also called a sliding fee) prevents me or my family from accessing healthcare services at Choptank:**
    a. Always
    b. Sometimes
    c. Never

4. **If you answered "Always" or "Sometimes" - Please tell us more about how the office visit fee creates a barrier to accessing health care:**

    _____
    _____
    _____
    _____

5. **How would you rate the value of the care you receive at Choptank Health?**
    a. Exceptional Value
    b. Moderate Value
    c. Little to no Value

6. **Is there anything else you'd like to tell us about the sliding "office visit" fee program, affordability of health care services, or general feedback about Choptank Community Health?**

    _____
    _____
    _____
    _____

***Thank you for fully completing our Sliding Fee Application & Assessment!***