Chesapeake HEALTH CARE

P.O. Box 1978
Salisbury, MD 21802-1978
Office 410-749-1015 Fax 410-749-1020

PLEASE RETURN APPLICATION IMMEDIATELY
TO ENSURE ACCURATE PROCESSING OF YOUR ACCOUNT

APPLICATION FOR SLIDING FEE SCALE

" **PLEASE PRINT** "

Date: ____/____/_____

Patient's Name: _____

Date of Birth: ____/____/_____ Social Security #: _____

Responsible Party: _____

Date of Birth: ____/____/_____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Employer: _____ Address: _____

Years Employed: _____ Salary: _____ Work Phone: _____

Spouse's Name: _____

Date of Birth: ____/____/_____ Social Security #: _____

Employer: _____ Address: _____

Years Employed: _____ Salary: _____ Work Phone: _____

Qualifying Level: ☐ Nominal ☐ 25% ☐ 50% ☐ 75%

Please list your family members (husband, wife and children under 18) who are claimed on your tax return.
(Proof of income for all listed must be returned within 7 days or at next scheduled appointment, whichever comes first.)

Name	Relationship	DOB	Employer	Salary	Social Security #

Comments: _____

Have you applied for Medical Assistance? Yes ☐ No ☐

If eligible, please provide Medical Assistance Member #: _____

Have you applied for MCHP? Yes ☐ No ☐

Do you have a State of Maryland pharmacy card? Yes ☐ No ☐

If yes, list identification #: _____

Please note that all applications must be updated annually.

IF YOU DO NOT HAVE INSURANCE, PLEASE ASK FOR ASSISTANCE FROM THE APPLICATION COUNSELOR.

I certify under penalties of perjury, that the above statements are true, accurate and complete to the best of my knowledge and belief.

_____ _____

Applicant / Guarantor's Signature Date

Has patient been referred to the Application Counselor? Yes ☐ No ☐

Medical Receptionist Printed Name: _____

Medical Receptionist Signature: _____ Date: _____

Documents Accepted as Proof of Income (POI):

- Pay Stubs (4 if paid weekly, 2 if paid biweekly)
- W2 Tax Form
- Tax Return (Line 22)
- Social Security (Staff: READ Contents of Letter)
- Bank Statement Showing Direct Deposits from Employer
- Unemployment (for 6 months)
- Letter from Employer

Documents Not Required:

- Disability
- Child Support
- Workers Compensation
- Temporary Cash Assistance
- SSI (Supplemental Security Income)
- Social Security Disability

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Chesapeake Health Care (CHC) for your healthcare needs. We are honored by your choice and we are committed to providing you with the highest quality healthcare. We ask that you read the following information to understand our policy regarding self-pay patients and the sliding fee scale discount that we offer, as follows:

Please be aware that CHC expects the information you provide to apply for the sliding fee discount to be true, complete and accurate. The information that you are providing concerning the size of your family (i.e., as family composition would be reported on an IRS tax return) and your family's gross annual income, from all sources (e.g., earned income, Social Security benefits, SSI, unemployment benefits, etc.), must be correct to the best of your knowledge. CHC may request additional information, if needed, to determine eligibility. You are also responsible for promptly notifying CHC of changes in insurance, family income or size.

CHC relies on the information concerning your financial situation and your means and ability to pay in order to determine the applicable discount for services rendered to you.

Therefore, if CHC has reason to suspect that the information you have given is untrue, incomplete or inaccurate or that you have not properly reported changes, CHC may initiate a review of your financial status. If you are found to have provided untrue information, you may be billed for any discounts you have received and possibly forfeit eligibility for the sliding fee program.

Application Counselors Contact Info:

Francina Jones
Certified Application Counselor
fjones@chesapeakehc.org
Cell: 443-397-3980
Princess Anne Site: 410-651-1000, Ext. 1350

Deirdrie Givens
Certified Application Counselor
dgivens@chesapeakehc.org
Cell: 443-397-3906
Woodbrooke Site: 410-546-6650, Ext. 1138

Carlene Wells
Certified Application Counselor
cwells@chesapeakehc.org
Cell: 443-754-5192
Healthway Site: 410-219-1100, Ext. 1025

_____ _____

Applicant Signature Date

_____ _____

Applicant Printed Name Date of Birth

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SELF DECLARATION OF INCOME / NO INCOME

I, _____, _____hereby state that my gross
(patient name – ***please print***) (DOB)

household income is $_____ (circle one: per week, per month, per year),

and that there are _____ members living in my household.

IF YOU DO NOT HAVE INSURANCE, PLEASE ASK FOR ASSISTANCE FROM THE APPLICATION COUNSELOR.

I understand that by signing this self-declaration my fees for today's visit may be reduced. In order to be eligible for continued reduced fees, I understand that I must provide CHC with a completed Application for Sliding Fee Scale and acceptable proof of income documentation. (Please see "Documents Accepted as Proof of Income" on Page 2 of the Application for Sliding Fee Scale.)

I understand by signing this self-declaration of "no income", I will be charged the nominal fee for services.

I understand I will verify any changes in my income at each appointment in any office of the health center.

_____ _____
Patient/Parent/Guardian Signature, if Minor Witness Signature

_____ _____
Patient/Parent/Guardian Printed Name, if Minor Witness Printed Name

_____ _____
Date Date