



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**

\_\_\_\_\_ Verify SS# on Maryland Website (if applicable) \_\_\_\_\_  
 (Initial)  
 \_\_\_\_\_ Not Eligible at Time of Service – Print Out Sheet & Attach \_\_\_\_\_  
 (Initial)

**“ PLEASE PRINT ”**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient’s Name: \_\_\_\_\_ Salary: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_  
 Responsible Party / Spouse: \_\_\_\_\_ Salary: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

I attest that I have **NO INCOME**.

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

Please list your family members (self, spouse and children up to 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	Social Security # (if applicable)

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you applied for Medical Assistance?  Yes  No

If eligible, please provide Medical Assistance Member #: \_\_\_\_\_

Are you a Maryland resident?  Yes  No

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

Have you applied for MCHP (Maryland Children's Health Program)?  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.**

**Documents Accepted as Proof of Income (POI):**

- Pay Stubs (minimum: 1 pay stub)
- 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, but please check means of support:**

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

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

**FOR OFFICE USE ONLY**

Has patient been referred to the Certified Application Counselor (CAC)?  Yes  No

Please write name of CAC: \_\_\_\_\_

_____	X	=	_____
# of Household	Gross	12 mo.	Total Amount

**Qualifying Level:**     Nominal     Level I     Level II     Level III

Medical Receptionist Printed Name: \_\_\_\_\_

Medical Receptionist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Receptionist Printed Name: \_\_\_\_\_

Medical Receptionist Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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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](mailto:fjones@chesapeakehc.org)  
Cell: 443-397-3980  
Princess Anne Site: 410-651-1000, Ext. 1350

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

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

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Applicant Signature

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Date

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Applicant Printed Name

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Date of Birth



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### SELF DECLARATION OF 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