



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**

**FOR OFFICE USE ONLY**

\_\_\_\_\_ Verify SS# on Maryland Medicaid EVS Website (if applicable) \_\_\_\_\_  
 (Initial)

\_\_\_\_\_ Not Eligible at Time of Service – Print Out Sheet & Attach \_\_\_\_\_  
 (Initial)

**“ PLEASE PRINT ”**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient’s Social Security #: \_\_\_\_\_

Patient’s Name: \_\_\_\_\_ Patient’s Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Responsible Party / Spouse Name: \_\_\_\_\_

Responsible Party / Spouse Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Responsible Party/ Spouse Social Security #: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you, or the patient you represent, have medical/dental insurance?  Yes  No

If YES, please provide your insurance card to the front desk representative.

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 #: \_\_\_\_\_

Eligibility for Chesapeake Health Care’s sliding fee scale financial assistance is based on income levels relative to the federal poverty guidelines published annually and the number of individuals living in your household. Certain sources of income are excluded from the calculation of household income (see below).

Please list the following MEMBERS of your household (self, spouse, significant other, and children, including step-children and legally adopted children, up to 18 years of age) and list ALL income earned by the listed members.

(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 #<br>(if applicable) | Yearly Income |
|------|--------------|-----|--------------------------------------|---------------|
|      | SELF         |     |                                      |               |
|      |              |     |                                      |               |
|      |              |     |                                      |               |
|      |              |     |                                      |               |
|      |              |     |                                      |               |
|      |              |     |                                      |               |
|      |              |     |                                      |               |
|      |              |     |                                      |               |
|      |              |     |                                      |               |

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

If no members of your household earn income used to calculate eligibility for the sliding fee scale, please check the box below and the appropriate box within the Means of Support.

I attest that all members of my household have **NO INCOME**.

**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 Form #1040 (Line 22)
- Tax Return Form #1040A (Line 15)
- Tax Return Form #1040EZ (Line 4)
- Social Security (Staff: READ Contents of Letter)
- Unemployment (for 6 months)
- Letter from Employer

**If You Attest to No Income, Please Check Means of Support:**

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

**Please answer the following survey questions:**

Chesapeake Health Care's nominal fee for medical and behavioral health services is \$25. Do you feel this charge is (check one):  Fair/Adequate  Too Expensive  Would Prevent Me From Seeking Care

If you checked "Too Expensive or Would Prevent Me From Seeking Care" please provide your opinion of an appropriate fee: \$ \_\_\_\_\_

CHC's nominal fee for basic, preventive and major dental services is \$40, \$60 and \$85, respectively. Do you feel these charges are (check one):  Fair/Adequate  Too Expensive  Would Prevent Me From Seeking Care. If you checked "Too Expensive or Would Prevent Me From Seeking Care" please provide your opinion of an appropriate fee: \$ \_\_\_\_\_

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: \_\_\_\_\_

Monthly: \_\_\_\_\_ X  $\frac{12}{12 \text{ mo.}}$  = \_\_\_\_\_  
          # in Household                          Gross    Total Amount

Weekly: \_\_\_\_\_ X  $\frac{52}{52 \text{ weeks}}$  = \_\_\_\_\_  
          # in Household                          Gross    Total Amount

Bi-Weekly: \_\_\_\_\_ X  $\frac{26}{26 \text{ weeks}}$  = \_\_\_\_\_  
          # in Household                          Gross    Total Amount

Qualifying Level:

Nominal

Level I

Level II

Level III

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

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



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

## 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. 1301

Deirdrie Givens  
Certified Application Counselor  
[dgivens@chesapeakehc.org](mailto:dgivens@chesapeakehc.org)  
Cell: 443-397-3906  
Woodbrooke OB/GYN Site: 410-546-2424, Ext. 1887

Carlene Wells  
Certified Application Counselor  
[cwells@chesapeakehc.org](mailto:cwells@chesapeakehc.org)  
Cell: 443-754-5192  
Phillip Morris Dr. Site: 410-548-1747, Ext. 1535

Abigail Cho  
Certified Application Counselor  
[acho@chesapeakehc.org](mailto:acho@chesapeakehc.org)  
Cell: 443-754-5193  
Woodbrooke Adult Site: 410-546-6650, Ext. 1114

---

Applicant Signature

---

Date

---

Applicant Printed Name

---

Date of Birth



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

**INFORMED CONSENT FOR REDUCED LAB FEES**

**" PLEASE PRINT "**

**Patient's Name** \_\_\_\_\_ **D.O.B.** \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby give consent to have lab work performed by Chesapeake Health Care (CHC). I understand I will receive reduced lab fees, provided I pay the day the service is performed. If payment is **NOT** received the day of service, I understand I will be billed and responsible for the LabCorp fees at a much higher rate. If I have insurance coverage, a deductible may have to be met. If additional confirmation, reflex and/or "add on" testing is deemed necessary by LabCorp and/or my provider, I understand my account will be charged for this/these test(s) at the discount rate.

\_\_\_\_\_  
Patient or Legal Guardian – *please print*

\_\_\_\_\_  
Patient Signature or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
CHC Witness – *please print*

\_\_\_\_\_  
CHC Witness Signature

\_\_\_\_\_  
Date