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

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 # (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 7b) **(total income)**
- ☐ Tax Return Form #1040SR (Line 7b) **(total income)**
- ☐ 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	12	=	_____
	# in Household	Gross		12 mo.		Total Amount
Weekly:	_____	_____	X	52	=	_____
	# in Household	Gross		52 weeks		Total Amount
Bi-Weekly:	_____	_____	X	26	=	_____
	# in Household	Gross		26 weeks		Total Amount

Qualifying Level: ☐ Nominal ☐ Level I ☐ Level II ☐ Level III

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
Cell: 443-397-3980
Princess Anne Site: 410-651-1000, Ext. 1301

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

Carlene Wells
Certified Application Counselor
cwells@chesapeakehc.org
Cell: 443-754-5193
Phillip Morris Dr. Site: 410-548-1747, Ext. 1535

Timyra Schoolfield
Certified Application Counselor
tschoolfield@chesapeakehc.org
Cell: 443-397-7698
Woodbrooke Adult Site: 410-546-6650, Ext. 1114

_____ _____

Applicant Signature Date

_____ _____

Applicant Printed Name Date of Birth

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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