



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 9) **(total income)**
- Tax Return Form #1040SR (Line 9) **(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
- Live with other family member
- 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.

\_\_\_\_\_ Date

Applicant / Guarantor’s Signature

**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

Annual: \_\_\_\_\_ X 1 = \_\_\_\_\_  
          # in Household           Gross           1 year           Total Amount

Qualifying Level:    Nominal    Level I    Level II    Level III

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

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