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 SSN / ITIN #: _____

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):

- ☐ Current Pay Stubs-within 90 days (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.

_____ _____

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
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: _____