

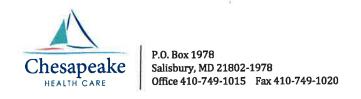
P.O. Box 1978 Salisbury, MD 21802-1978 Office 410-749-1015 Fax 410-749-1020

PLEASE RETURN APPLICATION IMMEDIATELY TO ENSURE ACCURATE PROCESSING OF YOUR ACCOUNT

APPLICATION FOR SLIDING FEE SCALE

	FOR OFFICE				1
	·		n Maryland Medicaid EVS at Time of Service – Print		(Initial)
EASE PRINT	"				
Date:	//_				
Patient's Nai	me:				Salary:
Date of Birth	:/_	/	Social S	ecurity #:	
Responsible	Party / Spo	ouse:			Salary:
Date of Birth://					
Street Addre	ss:				
City:		S	tate: Zip Co	de:	Phone:
By check	ing the bo		ME. under penalties of perj e best of my knowledge		e statements are true,
By check accurate Please list yo	ing the bo and comp ur family m	ox, I certify olete to the nembers (se	under penalties of perje best of my knowledge elf, spouse and children returned within 7 days or a	and belief. up to 18) who are out next scheduled app	claimed on your tax return. pointment, whichever comes fi
By check accurate Please list yo	ing the bo and comp ur family m	ox, I certify olete to the nembers (se	under penalties of perj e best of my knowledge elf, spouse and children	and belief. up to 18) who are o	claimed on your tax return. pointment, whichever comes fi
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☐ Yes ☐ No		
nber #:		
☐ Yes ☐ No		
ASSISTANCE FROM THE APPLICATION COUNSELOR.		
alth Program)?		
☐ Yes ☐ No		
tions must be updated annually.		
Documents Not Required, but please check means of support:		
☐ Disability		
☐ Child Support		
☐ Workers Compensation		
☐ Temporary Cash Assistance		
☐ SSI (Supplemental Security Income)		
☐ Social Security Disability		
Date		
FICE USE ONLY		
ation Counselor (CAC)?		
ation Counselor (CAC)?		
ation Counselor (CAC)?		
Ation Counselor (CAC)? Yes No X = 12 mo. Total Amount		
Ation Counselor (CAC)? Yes No No 12 mo. Total Amount Yel I Level II Level III		
Ation Counselor (CAC)? Yes		



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: 443-754-5192 Phillip Morris Dr. Site: 410-548-1747, Ext. 1535	Abigail Cho Certified Application Counselor acho@chesapeakehc.org Cell: 443-754-5193 Woodbrooke Adult Site: 410-546-6650, Ext. 1114
Applicant Signature	Date
Applicant Printed Name	Date of Birth



INFORMED CONSENT FOR REDUCED LAB FEES

" PLEASE PRINT "		
Patient's Name	D.O.B	
I hereby give consent to have lab work per will receive reduced lab fees, provided I pareceived the day of service, I understand I much higher rate. If I have insurance cover confirmation, reflex and/or "add on" testing understand my account will be charged for	y the day the service is performed. If p will be billed and responsible for the La rage, a deductible may have to be met. is deemed necessary by LabCorp and/	ayment is NOT bCorp fees at a If additional
Patient or Legal Guardian – please print	Patient Signature or Legal Guardian	Date
CHC Witness – please print	CHC Witness Signature	Date